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

MARY W. BRIMHALL, Plaintiff, vs. JO ANNE B. BARNHART, Commissioner of Social Security, Defendant.	)	No. 02-2549-MlV

REPORT AND RECOMMENDATION

The claimant, Mary W. Brimhall, appeals from a decision of the Administrative Law Judge of the Office of Hearings and Appeals ("ALJ"), denying her application for disability benefits under the Social Security Act. 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).

On appeal, Brimhall argues that the ALJ's decision is not supported by substantial evidence because 1) the ALJ failed to give proper weight to her treating medical source opinions; 2) the ALJ erred in giving only partial credibility to her hearing testimony, specifically by applying the now-defunct "sit-and-squirm" test; and 3) the ALJ failed to consider the relationship between her obesity and other impairments. For the reasons given below, this court

recommends that the decision of the ALJ be affirmed.

PROPOSED FINDINGS OF FACT

Brimhall first applied for social security disability and supplemental security income benefits October 8, 1999, due to a neurological sleep disorder, alleging a disability onset date of December 2, 1998. (R. at 73-76.) The application was denied initially and upon reconsideration. Brimhall then filed a request for a hearing, which was duly held on February 14, 2001 before an Administrative Law Judge (ALJ). (R. at 24.) The ALJ issued an unfavorable decision on April 17, 2001. (R. at 9.) Brimhall appealed the ALJ's decision to the Appeals Council, which denied the request for review on May 11, 2002, leaving the ALJ's decision as the final decision. (R. at 4-5.) The Appeals Council specifically considered new regulations governing musculoskeletal and related impairments, effective February 19, 2002, and determined that the new regulations provided no basis for a different outcome. (R. at 4.) Brimhall filed this suit in federal district court on July 11, 2002, pursuant to 42 U.S.C. § 405(g), alleging that she is unable to perform substantial gainful activity and that the decision denying her claim was unsupported by substantial evidence and the result of an incorrect application of law by the ALJ.

Brimhall was born on August 17, 1943 and was fifty-seven years

old at the time of the hearing. (R. at 25.) She is a high school graduate, (R. at 26), and has also completed informal correspondence study, vocational study, and college classes roughly equivalent to one year of college, (R. at 26-28).

Brimhall's longest past relevant employment was from 1975 to 1983 as an officer worker for a truck line. (R. at 100, 107.) At this job, Brimhall typed, filed, prepared deposits, typed bills and put them on a manifest list, and made copies. (R. at 102.) Most recently, she worked in the office at her husband's transportation company, Brimhall Piggyback Services, from 1985 until her claimed onset date of December 2, 1998. (R. at 28, 100-01.) Her job duties included typing, sending invoices and mailings, answering the telephone, preparing bank deposits, and completing insurance and workers' compensation forms. (R. at 101.) About half her work was on a computer. (R. at 29.) After December 2, 1998, she was not on the company payroll, but occasionally would go into the office to help train new employees. (R. at 33.) During these visits, which occurred once or twice per week, she would stay at the office one to three hours. (R. at 34.) She claimed she stopped working regularly due to her health. (R. at 28-29.) She testified that her work effectiveness was limited to between one and four hours and that if she stayed any longer she would lie down for an hour on a bed located on the premises. (R. at 40.)

At the time of the hearing, Brimhall's daily activities included laundry. (R. at 34.) She testified that she lived with her husband who did most of the cooking, (R. 26, 35), and that a housekeeper or relative did the household cleaning, (R. at 34). She did some grocery shopping with her husband, (R. at 35), but leaned on the cart like a crutch, (R. at 38). She grocery shopped less than once a week. (R. at 42.) She occasionally would pay bills and reconcile the check register but had not done so for four or five months. (R. at 36.) She was able to drive for short periods but indicated her doctors had restricted her driving to between 10 and 30 minutes at a time. (R. at 35.)

As to her daily health management, Brimhall had been advised to walk for exercise but did not do so because of pain in her neck, arm, leg, and right hip. (R. at 30-32, 36-37.) She relieved pain by sitting or lying down and by taking medication. (R. at 37.) She tested her own blood sugar every morning and followed a diabetes diet. (R. at 30.) Each night, she slept with a C-PAP to control sleep apnea (interrupted breathing during sleep). (R. at 31.)

At the hearing, Brimhall testified concerning her medical problems and symptoms. She first testified to problems with excessive daytime sleepiness or hypersomnia. (R. at 28, 39.) She characterized this as her primary health problem. (R. at 39.) She

testified that this condition rendered her unable to remain alert and maintain concentration at work. (R. at 28.) She testified the lack of sleep made her easily susceptible to stress, (R. at 38), and that it limited her driving to no more than 15 continuous minutes. (R. at 35.) She testified that her doctor had recommended structured naps of 45 minutes in the afternoons and that she sometimes sleeps longer. (R. at 39.) She testified that she frequently "nodded off," especially in quiet surroundings. (R. at 39-40, 44.)

Brimhall also testified to various symptoms of pain. She testified to pain in the neck, hip, and leg that she attributed to arthritis. (R. at 33.) She also complained of pain in the neck and arm that she attributed to lupus. (R. at 32-33.) She testified that the pain in her right hip prevented her from walking as much as half a block. (R. at 36-37.) She testified that she could not stand for more than a minute without pain, could not sit for long periods of time without her hip hurting, and had to lie down between periods of sitting. (R. 36-37, 39.) She testified that she had to take breaks during grocery shopping to sit down, but that during those breaks she could stand and walk to the aisles to look at products. (R. at 42.) She testified that she could lift up to ten pounds. (R. at 38.)

Finally, Brimhall testified to diabetes, (R. at 29), high

blood pressure (R. at 32), headaches, (R. at 41), and depression (R. at 47). She testified that her treatment with diuretics required frequent bathroom visits: every twenty minutes for the first three hours after taking the medication, then once an hour for the rest of the day. (R. at 39, 45.) She indicated she had not taken her diuretic the day of the hearing. (R. at 45.) She did not testify to specific symptoms associated with any of the other disorders, but did state that medication did "a fair job" of controlling her depression and that depression did not really affect her daily interactions. (R. at 47.)

Brimhall regularly treated with several physicians. She treated with internist Mark Vlasak, M.D. of Foundation Medical Group from May 9, 1994 to December 1, 2000; with Srinath Bellur, M.D. and Neal Aguillard, M.D. at Methodist Hospitals of Memphis Sleep Disorders Center from January 1997 through December of 1999; with psychiatrist Melvin Goldin, M.D. from June 5, 1998 through February 7, 2000; again with Dr. Bellur at Wesley Neurology Clinic from January 5, 1999 through October of 2000; and with Maher Ghawji, M.D. of Endocrinology Associates from June of 1999 to October of 2000.

The record also contains physician reports and opinions. First, Brimhall's treating physicians produced two Residual Functional Capacity Assessment ("RFC") reports: the first by Mark

Vlasak, M.D., dated December 21, 2000, and the second by Srinath Bellur, M.D., undated. Examining but non-treating psychologist Duff Wright, Ph.D. provided a mental capacity report for Tennessee Disability Determination Services on November 16, 1999. The record also contains four opinions from non-treating, non-examining physicians: a Psychiatric Review Technique Form with a Capacity Assessment from Ed Sachs, Ph.D., dated November 19, 1999; an RFC from Reeta Misra, M.D., dated November 23, 1999; a Psychiatric Review Technique Form with a Capacity Assessment from Victor Pestrak, Ph.D, dated March 8, 2000; and an RFC from Sorin or Robin Richard, M.D., dated March 9, 2000.

Brimhall's longitudinal records begin with a complaint of right neck pain on May 9, 1994. Mark Vlasak, M.D., Brimhall's internist, symptomatically treated this and several situational illnesses in May and June of 1994. (R. at 309-310.) In June of 1994, Brimhall complained of hopelessness, nervousness, and depression. She was, at that time, taking two amphetamines, phentermine and pondimin, prescribed by another physician. (R. at 310.) Her weight was 247. (*Id.*) Dr. Vlasak diagnosed "major depression, probably secondary to amphetamines." (*Id.*)

A year passed until the next relevant medical treatment, which was a visit to Dr. Vlasak on January 1, 1995, with the concern that Prozac was causing weight gain. Brimhall discontinued her Prozac

and started Serzone. (R. at 311.) In September of that year, Dr. Vlasak characterized Brimhall's condition as "a myriad of problems, including essential hypertension, morbid obesity, major depressive disorder, [and] idiopathic rash." (R. at 312.) The hypertension was under "fair control." (*Id.*) Dr. Vlasak adjusted existing medications and prescribed various dosages of Prozac. (*Id.*)

There is no other treatment of record for the remainder of 1995, and only one relevant medical visit occurred in 1996. On August 23, 1996, Brimhall reported to Dr. Vlasak with "right hip aching pain and extreme fatigue for several months." (R. at 315.) Blood tests were ordered but no specific treatments recommended. (*Id.*)

As of January 9, 1997, Brimhall's complaints of fatigue and daytime sleepiness continue to appear in records from her internist, Mark Vlasak. (R. at 277.) She indicated she "sleeps too much." (R. at 277, 316.) Over the prior five months she had been obese and had complained of situational illnesses as well as right hip pain and extreme fatigue, but not of specific daytime sleepiness. (R. at 277). Dr. Vlasak recommended a study to rule out sleep apnea or narcolepsy. (*Id.*)

On January 27, 1997, Brimhall reported to Methodist Hospitals of Memphis Sleep Disorders Center for the first night of a three-night sleep study that continued until September 30, 1997.

Brimhall was 249 pounds at five feet, three inches tall. (R. at 214.) It appears Brimhall had no significant medical treatment other than the sleep study between January and October of 1997.

The first night of Brimhall's sleep study, conducted January 27, 2001, revealed "a loss of REM [rapid eye movement] sleep and an excessive amount of state 1 sleep and awake time." (*Id.*) At least one period of REM movement appeared. (R. at 215.) Neal Aguillard, M.D., diagnosed obstructive sleep apnea syndrome "that is severe based on her respiratory disturbance index . . . [and] associated with severe and persistent oxygen desaturations." (R. at 214.) Secondarily, he diagnosed hypertension that could be exacerbating the sleep apnea; "severe sleepiness based on her multiple sleep latency test"; depression that could be contributing to daytime sleepiness; and probable cor pulmonale (an enlargement of the heart associated with pulmonary disorder). (R. at 215.) He recommended a continuous positive airway machine (CPAP) and ordered Brimhall to return for CPAP titration, i.e., testing for optimum CPAP air pressure. (*Id.*)

On April 4, 1997, the second night of the sleep study, Dr. Aguillard found "an excessive amount of REM sleep" as well as "an excessive amount of state 1 sleep." (R. at 393.) He diagnosed obstructive sleep apnea syndrome that was severe and associated with "severe oxygen desaturations" but noted it was "corrected with

9 centimeters" of CPAP pressure. (*Id.*) He also noted severe daytime sleepiness; depression that possibly was contributing to daytime sleepiness and sleep disruption; hypertension; and probable cor pulmonale. (R. at 394.) Brimhall was advised to set the nasal CPAP at nine centimeters while sleeping and follow up with the remainder of the sleep study. (*Id.*)

On September 30, 1997, Brimhall reported for the third and final night of the sleep study. (R. at 197, 198.) The Sleep Center's neurologist, Srinath Bellur, M.D., reported that Brimhall was "abnormally sleepy to a moderate degree" but ruled out narcolepsy. (R. at 198.) He noted modest improvement since January of 1997 but still abnormal sleepiness. (*Id.*) Dr. Bellur advised Brimhall to avoid drinking alcohol and to avoid using medications with sleepiness side effects. (*Id.*) He also advised Brimhall to "exercise extreme caution when undertaking any activity requiring alertness . . . such as driving, working with actively moving machinery, and working at heights." (*Id.*) No REM periods were noted. (R. at 199.) Brimhall's CPAP was increased to fifteen centimeters. (R. at 204.)

On October 29, 1997, Brimhall returned to Dr. Vlasak. She reported no change in her energy level despite her CPAP use. (R. at 274.) She had attempted to taper off Prozac but experienced increased irritability. (*Id.*) A five-month gap in the treatment

records follows until April 30, 1998, when Brimhall reported to Dr. Vlasak with aching joints and daytime fatigue. She requested stimulants. (R. at 272.) She was continued on the diuretic Demadex and on Cozaar; her Prozac was increased to 10mg and her weight was 258. (*Id.*)[1]

According to the record, between June 5, 1998 and September 10, 1998, Brimhall received psychological treatment only. On June 5, 1998, at Dr. Vlasak's recommendation, Brimhall met with psychiatrist Melvin Goldin, M.D. Dr. Goldin diagnosed an Axis IV depressive disorder not otherwise specified, "with elements of chronic dysthymia" and stimulant withdrawal as a possible factor. (R. at 259.) Dr. Goldin found Brimhall "grossly preoccupied with her need for stimulant medication," and noted her reports of sleeping twelve or thirteen hours each day. (R. at 258-59.) He recommended that she discontinue Prozac and prescribed Wellbutrin in its place. (R. at 259.) On July 29, 1998, Brimhall saw Dr. Goldin again and reported that she still generally was not feeling well. (R. at 257.) At this time she was on Wellbutrin. (R. at 255.)

On September 10, 1998, Brimhall returned to internist Mark

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[1] **There is come confusion over whether medications were discontinued. At page 274, the record seems to indicate prescriptions for Cozaar, Demadex, Prozac 20mg, and an anti-inflammatory.**

Vlasak with "excessive thirst, urination, and fatigue." (R. at 272.) Dr. Vlasak diagnosed adult onset diabetes and prescribed the medication Amaryl as well as a diabetic diet. (*Id.*) Brimhall visited Dr. Goldin on September 16, 1998. She noted daytime somnolence and hypoglycemia, but the chart entry contains no specific mental complaints. (R. at 257.) On September 24, 1998, Brimhall reported less urinary frequency but continued dry mouth and blurred vision, apparently in response to diabetes control drugs. (R. at 271.)

On October 28, 1998, Brimhall presented for follow-up at the Sleep Disorders Center. She reported some improvement but continued daytime sleepiness. (R. at 194.) Dr. Aguillard confirmed obstructive sleep apnea syndrome, "that is severe and is probably corrected with the use of auto continuous positive airway machine (CPAP)," severe daytime sleepiness, and persistent daytime sleepiness possibly related to idiopathic hypersomnia ("subwakefulness syndrome"), hypertension, and depression that was being treated with Wellbutrin. (R. at 194, 402.) He recommended a referral to neurologist Srinath Bellur, M.D. for possible stimulant therapy. (R. at 195.)

On November 11, 1998, Brimhall saw Dr. Goldin but did not discuss any specific mental complaints. (R. at 257.) Her prescription for Wellbutrin was renewed. (R. at 255.) Brimhall's

alleged date of onset is December 2, 1998. Her Amaryl prescriptions were twice renewed in December of 1998, (R. at 271), but there is no evidence of other medical treatment during that month.

Brimhall met with Dr. Bellur on January 5, 1999. He diagnosed "severe obstructive sleep apnea syndrome," potentially "either . . . atypical narcolepsy or idiopathic hypersomnia syndrome." (R. at 229.) He noted past medical history of long-standing depression. (*Id.*) Dr. Bellur instructed Brimhall not to drive, operate moving machinery, or work at heights, and to avoid sedative drugs and alcohol. (*Id.*) He ordered additional tests including a complete blood count (CBC); a comprehensive metabolic panel (CMPAN); tests for two hormones associated with the thyroid (T4 and TSH); tests for vitamin B12; a narcolepsy screening; and a CT of the head. (R. at 229, 232-234.) The narcolepsy screening was positive for HLA DQ1, a substance associated with narcolepsy. (R. at 232.) The CT scan was normal. (R. at 193.)

On February 12, 1999, Brimhall reported to Dr. Bellur for a follow-up after a sleep lab evaluation. He declined to prescribe Ritalin because of Brimhall's blood pressure but planned to start the narcolepsy drug and antidepressant potentiate modafanil (brand-named Provigil) upon its market release the following week. (R. at 228.) On March 17, 1999, Brimhall discussed her treatment with psychiatrist Melvin Goldin but did not discuss any specific mental

complaints. (R. at 257.) Her prescription for Wellbutrin was renewed. (R. at 255.)

The next medical consultation is May 1, 1999, when Dr. Goldin switched Brimhall from Wellbutrin to Zoloft. At this time he did not indicate any specific mental complaints. (R. at 255, 257.) On May 12, 1999, Brimhall met with Dr. Bellur to discuss risks and side effects for modafanil (Provigil). She was advised to ask Dr. Goldin about the risk of drug synergy with Wellbutrin. (R. at 226.)

On June 4, 1999, Brimhall reported to her internist, Dr. Vlasak, of left neck pain and stiffness radiating down her left shoulder and into the left neck. (R. at 269.) The neck pain was symptomatically treated, and her blood pressure and diabetes medications were continued. (*Id.*) Shortly thereafter, she received Avandia, an additional diabetes medication which was discontinued within ten days due to an allergic rash. (*Id.*) On June 23, 1999, Brimhall reported to Dr. Bellur with a continuing complaint of feeling tired. He indicated she could increase her Provigil but that she must monitor her blood pressure to do so. (R. at 223.) Apparently she had discontinued Wellbutrin and replaced it with Zoloft, (R. at 224), although a prescription note indicates she might have been taking Wellbutrin, (R. at 225). She was also taking Cozaar for blood pressure. (R. at 262.)

On July 7, 1999, Brimhall reported to Dr. Goldin a better mood state but muscle stiffness and a low response to Provigil. (R. at 253.) She was continued on Zoloft. (R. at 254.) On July 15, 1999, by referral, Brimhall visited Dr. Ghawji of Endocrine Associates. He diagnosed obesity, sleep apnea, depression, and poorly controlled diabetic symptoms. (R. at 245.) Brimhall returned to Dr. Bellur on July 29, 1999, noting that the Provigil was not really helping her. He recommended against the stimulant Ritalin but suggested she discuss it with her internist. (R. at 222.) He noted that Brimhall "does not appear to be depressed now and does not complain of depression." (*Id.*) She was still taking Cozaar. (R. at 262.)

On August 13, 1999, Brimhall reported to Dr. Ghawji of Endocrine Associates with a generally unchanged condition. (R. at 242.) Dr. Ghawji noted "poorly controlled" diabetes, treated with Amaryl but uncontrolled by diet or self-tests. (R. at 266.) He indicated the major diabetes-related problems were poor dietary compliance and morbid obesity. (R. at 267.) Brimhall's weight at the time was 248. (R. at 266.) Blood tests revealed improvement in her cholesterol. (R. at 243.) On August 23, 1999, Brimhall returned to the Methodist Hospitals of Memphis Sleep Disorders Center for a multiple daytime napping test. The test revealed she was "abnormally sleepy to a severe degree" but ruled out

narcolepsy. (R. at 187, 189.) The test did not note any REM associated with sleep onset. (R. at 189.) Dr. Bellur of the Sleep Disorders Center advised Brimhall to "refrain from any activity requiring alertness . . . such as driving, working with actively moving machinery, and working at heights." (R. at 187.) He also advised Brimhall to avoid sedatives or hypnotic drugs and alcohol. (R. at 189.)

As of September 2, 1999, Dr. Bellur noted that Brimhall's condition was not responsive to stimulants and opined that Brimhall was "completely disabled medically." (R. at 223.) He instructed her not to drive, work with moving machinery, or work at heights. (R. at 223.) On September 8, 1999, Brimhall saw Dr. Goldin, complaining of daytime sleepiness and inquiring about stimulants. Dr. Goldin noted that using Schedule II drugs to treat daytime somnolence was not a legal use in Tennessee and discussed with Brimhall a return to Prozac "in hopes of boosting energy by day." (R. at 253.) On September 17, 1999, Brimhall consulted Dr. Bellur about using Ritalin, and he cautioned her about the risks of interaction between Ritalin and high blood pressure. Nonetheless, he noted that an internist may prescribe Ritalin in combination with a hypertensive agent. (R. at 221.)

On October 7, 1999, Brimhall reported to her psychiatrist an affective slump, lasting about two days, and easy fatigue. (R. at

253.) He specifically recommended not driving. (*Id.*) On October 14, 1999, Brimhall reported to Dr. Ghawji of Endocrine Associates that Provigil was not effective and she felt better on her previous medication, phentermine. (R. at 239, 265.) Her antidepressant at the time was Prozac, 60mg per day. (R. at 239.) The diagnostic notes indicated morbid obesity, sleep apnea, and fibromyalgia. (*Id.*) Blood tests revealed "much better" glucose levels. (R. at 240.) Her weight was 246. (R. at 241.) Her Cozaar prescription was continued. (R. at 262.)

On November 15, 1999, Brimhall complained to Dr. Goldin of dysthymia, low energy, and easy fatigue despite Provigil. (R. at 253.) On December 8, 1999, Brimhall reported to Dr. Goldin a somewhat better mood but still complained of easy fatigue and struggling to stay awake. (*Id.*) She also reported olfactory hallucinations of burning wire, coffee, and bacon. (R. at 360.)

On December 12, 1999, Brimhall again saw Dr. Bellur and reported that she had attempted to discontinue Provigil but her condition became worse. (R. at 220.) She was taking daily Provigil but still suffering from daytime sleepiness and needing "a couple of structured naps" each day. (*Id.*) She was still taking Amaryl for diabetes. (R. at 262.) On December 23, 1999, an MRI of the brain at Methodist Hospitals Germantown revealed no abnormality. (R. at 185.) Four days later, Brimhall consulted Dr.

Bellur for discussion of olfactory and auditory hallucinations that included smells of baked goods and burning wires in the morning. (R. at 219.) She reported some spontaneous improvement and denied blacking out; Dr. Bellur opined that her symptoms were not typical of temporal lobe seizures. (*Id.*)

On January 13, 2000, Brimhall reported to Dr. Ghawji of Endocrine Associates that she was feeling tired all the time and had right hip pain. (R. at 236.) Her weight was 251. (R. at 237.) Blood tests revealed "excellent" glucose levels and "good" cholesterol/lipid levels. (R. at 238.) She continued to take Cozaar. (R. at 264.)

On February 7, 2000, Brimhall reported to Dr. Goldin, her psychiatrist, that she attempted to discontinue all medications but resumed all except Prozac. (R. at 251.) She "express[ed] skepticism" about physical therapy, inquiring about stimulants instead. (*Id.*) She admitted to suicidal feelings two weeks beforehand but indicated they had cleared up. (*Id.*) Dr. Goldin renewed her Prozac prescription. (R. at 252.) On February 10, 2000, Brimhall reported to Dr. Vlasak that she had suffered from bad headaches and body aches for about four days; she apparently had discontinued Prozac on her own initiative. (R. at 262.)

On April 13, 2000, Dr. Ghawji of Endocrinology Associates reported that Brimhall was more compliant with her diabetes diet.

(R. at 304.) He observed menopausal symptoms, a new diagnosis, and most of Brimhall's other medications were continued. (*Id.*) Brimhall's condition had not significantly changed as of May 25, 2000, (*see* R. at 357), after which there is a gap in treatment until October of 2000.

On October 4, 2000, Brimhall reported to Dr. Ghawji of Endocrinology Associates that she was still sleepy and tired. She reported she was off Amaryl and not feeling depressed. (R. at 303.) She had not followed through on lipid testing that the doctor had requested. Her weight was 264, and she asked for diet pills. (*Id.*) Dr. Ghawji recommended dieting and the appetite suppressant phentermine. (*Id.*) He advised Dr. Vlasak by letter that Brimhall "would definitely benefit from weight loss" and that he would "add a small dose of phentermine . . . on a trial basis," with instructions for Brimhall to carefully monitor her blood pressure after taking it. (R. at 348.)

Brimhall then did not treat until December 1, 2000, which is the last longitudinal treatment visit on record. It reflects a complaint to Dr. Vlasak of back and shoulder pain, an increase in pain over the previous two months, "and now trouble walking." (R. at 323.) Current medications were continued. (*Id.*)

In addition to records of regular medical treatment, the record contains reports and opinions by two treating sources, one

examining but non-treating source, and four non-examining, non-treating sources.

Brimhall's treating physicians generated two physical RFC assessments. On December 21, 2000, Brimhall's internist, Mark Vlasak, M.D., opined that Brimhall could stand not more than 2 hours at a time or 2 hours in a workday; could sit not more than 2 hours at a time or 2 hours in a workday; could drive a vehicle only 10-30 minutes at a time; occasionally could lift and carry up to 10 pounds; could not repetitively use either hands or feet to push, pull, or manipulate; could not balance; was occasionally able to bend, kneel, squat, climb steps and ladders, reach, crawl, and rotate. He indicated environmental limitations of "No dust, heights, extreme heat/cold." Finally, he indicated Brimhall could "never" return to full or light duty work. (R. at 307.)

On an unknown date, Brimhall's neurologist, Srinath Bellur, M.D., opined that Brimhall could stand not more than 4 hours at a time or 4 hours in a workday; could sit not more than 2 hours at a time; should not drive a vehicle; occasionally could lift and carry up to 10 pounds; had no limitations on repetitive use of hands or feet to push, pull, or manipulate; had no limitations on balance; and was frequently able to bend, kneel, squat, reach, crawl, and rotate, but never able to climb ladders. He indicated Brimhall should "[a]void extremes of temp[erature]." (R. at 352.)

Finally, he indicated Brimhall could "never" return to light duty work, and that "severe daytime sleepiness" prevented her from driving, working with machinery, or working at heights. (*Id.*)

Duff Wright, Ph.D., a non-treating psychiatrist on behalf of Tennessee Disability Determination Services, examined Brimhall and produced a report on November 16, 1999. Brimhall reported to Dr. Wright a history of nerves and mood; easy irritability; lassitude; crying spells that "come and go"; unhappy feelings associated with being "always sleepy, tired and hurting"; some suicidal thinking without specific plan; and often feeling that life was hopeless or too difficult. (R. at 153.) She also reported problems with her temper, belief that her memory was declining, and that "her mind sometimes goes blank." (*Id.*) Dr. Wright diagnosed an Axis I depressive disorder not otherwise specified, "possibly secondary to unspecified sleep disorder," and an Axis III unspecified sleep disorder "by report." (R. at 161.) He concluded, after testing, that Brimhall could understand and remember instructions given to her; did not have a mental impairment of concentration or attention; and did not have significantly impaired adaptive living or socialization skills. (R. at 162.) Dr. Wright specifically limited his evaluation to mental limitations and did not evaluate the extent to which Brimhall's physical complaints affected her work capacity. (*Id.*)

The record contains four additional RFCs - two mental and two physical - generated by non-treating, non-examining sources. On November 19, 1999, DDS psychiatrist Ed Sachs, Ph.D., completed a mental RFC. He concluded that Brimhall showed signs of disturbance of mood evidenced by a depressive disorder not otherwise specified. (R. at 166.) Dr. Sachs reported a "moderate" restriction of activities of daily living; a "slight" difficulty in maintaining social functioning; that Brimhall "often" experienced deficiencies of concentration, persistence, or pace; but that Brimhall "never" experienced episodes of decompensation or deterioration in a work-like setting. (R. at 170.)

On March 8, 2000, DDS psychiatrist Victor Pestrak, Ph.D., completed a second mental RFC. He similarly concluded that Brimhall showed signs of disturbance of mood as evidenced by depressive disorder not otherwise specified. (R. at 282.) Dr. Pestrak reported a "moderate" restriction of activities of daily living; a "slight to moderate" difficulty in maintaining social functioning; that Brimhall "often" experienced deficiencies of concentration, persistence, or pace; but that Brimhall "never" experienced episodes of decompensation or deterioration in a work-like setting. (R. at 286.)

DDS physician Reeta Misra, M.D., completed a physical RFC on November 23, 1999. Dr. Misra's primary diagnosis was "sleep

disorder." (R. at 176.) The RFC opined that Brimhall could "occasionally" lift or carry 50 pounds; "frequently" lift or carry 25 pounds; stand or walk 6 hours of an 8-hour workday; sit 6 hours of an 8-hour workday, and was not limited in any pushing or pulling of hand or foot controls. (R. at 177.) The RFC indicated Brimhall could "frequently" balance, stoop, kneel, crouch, crawl, and climb ramps, stairs, ladders, ropes and scaffolds, (R. at 178), but contradictorily indicated Brimhall must avoid all exposure to "Hazards: machinery, heights, etc," (R. at 180.) Dr. Misra indicated that the treating source statements on file were not significantly different from these findings. (R. at 182.) The RFC concluded the condition "is severe but [illegible]" that "sleep apnea [is] medically treated" and indicated "obesity, DM with mild [illegible, perhaps "peripheral"] neuropathy." (R. at 183.)

The final physical RFC was completed by DDS physician Sorin or Robin Richard, M.D., on March 9, 2000. The primary diagnosis is "sleep apnea" with a secondary diagnosis of "NIDDM HTN" (non-insulin dependent diabetes mellitus and hypertension). (R. at 292.) Dr. Richard's findings were identical to those of Dr. Misra: that Brimhall could "occasionally" lift or carry 50 pounds; "frequently" lift or carry 25 pounds; stand or walk 6 hours of an 8-hour workday; sit 6 hours of an 8-hour workday, and was not limited in any pushing or pulling of hand or foot controls. (R. at

293.) The RFC indicated Brimhall could "frequently" balance, stoop, kneel, crouch, crawl, and climb ramps or stairs, but that Brimhall never should climb ladders, ropes or scaffolds. (R. at 294.) Dr. Richard also opined that Brimhall must avoid all exposure to "Hazards: machinery, heights, etc." (R. at 296.) He indicated that the treating source statements on file were not significantly different from these findings. (R. at 298.)

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 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).

Using the five-step disability analysis, the ALJ in this case found, as the first step in the evaluation, that Brimhall had not engaged in any substantial gainful activity since her claimed onset date. (R. at 18.) At the second step in the five-step analysis, the ALJ found that Brimhall's obesity, hypertensive cardiovascular disease, non-insulin dependent diabetes mellitus, obstructive sleep apnea, and depressive disorder all met the twelve-month duration requirement. (R. at 13.) After a review of Brimhall's medical treatment, however, the ALJ concluded that of these conditions only the obesity and obstructive sleep apnea could be defined as "severe," because the remaining conditions were controlled with medication. (R. at 16.) While the ALJ noted that Brimhall had been referred to the Sleep Disorders Center for evaluation of hypersomnia, (R. at 13), he limited his finding to obstructive sleep apnea, (R. at 16).

At the third step, the ALJ determined that the record did not show an impairment or combination of impairments that would meet or equal the level of severity described for any listed impairment set forth in 20 C.F.R. Part 404, Subpart P, Appendix 1. (R. at 16.)

In reaching this conclusion, the ALJ considered the opinions of the Disability Determination Service medical consultants issued at the initial application and reconsideration stages of the proceeding. (*Id.*)

At the fourth step in the analysis, the ALJ determined that Brimhall had the residual functional capacity to perform past relevant work and that, therefore, she was not disabled. (R. at 18.) The ALJ based his decision on the medical opinions in the record, upon the underlying medical records, and only partially upon Brimhall's subjective testimony. (R. at 17.) The ALJ partially relied on the DDS medical consultants' findings to find that Brimhall was capable of lifting, carrying, pushing, and pulling 10 pounds occasionally and "small objects" frequently; capable of standing and walking for two hours in an eight-hour workday; capable of sitting for six hours in an eight-hour workday; and able to perform a full range of work at the sedentary level because such work did not infringe on Brimhall's environmental limitations that required avoidance of moving mechanical parts; electrical shocks; high, exposed places; or exposure to hazardous materials. (*Id.*)

The ALJ partially discredited treating internist Vlasak's physical RFC because he found its limitations "excessive when compared to the accompanying medical records" and that the report

failed to relate the limitations to specific medical conditions. (*Id.*) The ALJ also partially discredited treating neurologist Bellur's physical RFC because it contradicted Dr. Vlasak's RFC in several places and because "the claimant testified that Dr. Bellur was not fully aware of her functional abilities." (*Id.*) As to mental limitations, the ALJ adopted the findings of examining but non-treating psychiatrist Wright, who indicated no significant mental limitations, over the findings of the non-examining and non-treating DDS physicians, who indicated some mental limitations. (R. at 16.)[2]

Finally, the ALJ partially discredited Brimhall's subjective testimony due to "many inconsistencies in the claimant's hearing testimony, the voluminous written statements from her and others who know her . . . and her statements to the psychological examiner." (R. at 15.) The ALJ also found Brimhall's testimony less credible because of "inconsistencies between her allegations and the negative findings described in the medical evidence and . . . inconsistency between the level of severity she described and the low level and infrequent nature of her medical treatment." (R. at 16.) He noted that Brimhall had abandoned her psychotherapy and also that no treating physician had referred her to an orthopedist

[2] There is no treating source RFC on the record for mental limitations.

or other specialist of a type that usually would be consulted for the walking and standing problems to which she testified. (*Id.*) The ALJ also observed inconsistencies between Brimhall's demeanor at the hearing and statements made to Dr. Wright, the examining psychiatrist. (*Id.*)

The ALJ concluded that Brimhall remained capable of performing her past relevant work as an office manager. (R. at 17-18.) Accordingly, he did not reach the fifth step to inquire whether she was able to perform other work existing in significant numbers in the national economy.

PROPOSED CONCLUSIONS OF LAW

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)). This standard applies 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). In addition, 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).

Brimhall's objections to the ALJ's decision arise at the third step of the decision-making process. First, she contends the ALJ failed to give proper weight to her treating medical source opinions. Second, she contends the ALJ erred in giving only partial credibility to her hearing testimony, specifically that the ALJ applied the now-defunct "sit-and-squirm" test. Third, she contends the ALJ failed to consider the relationship between her obesity and other impairments.

As to Brimhall's first contention, 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 sufficient clinical findings and are consistent with the evidence, 20 C.F.R. § 404.1527(d)(2); *Cutlip*, 25 F.3d at 287. The lack of "detailed, clinical, diagnostic evidence" can render a treating physician's opinion less creditworthy. *Walters v. Comm'r of Social Security*, 127 F.3d 525, 530 (6th Cir. 1997).

In this case, it does not appear that the ALJ disregarded the opinions of the Brimhall's treating physicians or that he substituted his own medical opinions for those of the treating physicians. Rather, the ALJ duly noted Brimhall's full course of treatment. He chose to discredit the treating physicians' RFCs

because he found them unsupported by clinical evidence. The court submits that the ALJ's determination is correct; there is no significant diagnostic evidence on record indicating osteopathic disorders, degenerative diseases, or even obesity interference with range of motion that reasonably would be expected to accompany severe physical limitations. In addition, the ALJ did partially credit the treating physicians' recommendations. The ALJ specifically noted that the DDS physicians' assessments seemed "overly optimistic" in light of the longitudinal treatment records. (R. at 17.) His conclusion that Brimhall could lift and carry ten pounds is consistent with the treating physicians' opinions, rather than those of the DDS physicians who suggested Brimhall could lift or carry up to twenty-five pounds. His conclusion that Brimhall could walk and stand two hours of an eight-hour workday is consistent with the treating physicians' opinions, rather than those of the DDS physicians who suggested Brimhall could walk or stand for six hours per day. His conclusion that Brimhall could sit for six hours a day differs from Dr. Valasak's opinion that Brimhall could not sit more than two hours a day. However, Dr. Bellur, her treating neurologist, opined that Brimhall could not sit more than two hours at a time but he placed no limit on the total number of hours a day Brimhall could sit. Thus, to the extent that Brimhall's prior job allows her to move around, the

ALJ's opinion is consistent with Dr. Bellur's. Moreover, despite Brimhall's testimony that she needed several naps a day, her treating doctors had only prescribed one structured nap of 45 minutes a day. Accordingly, it is submitted that the ALJ gave appropriate weight to the medical source opinions when determining Brimhall's residual functional capacity.

Brimhall's second challenge to the ALJ's findings alleges the ALJ applied the now-discredited "sit and squirm" test when he noted Brimhall's ability to sit for at least thirty minutes at the hearing. The Sixth Circuit has determined that an ALJ may not solely rely on a claimant's behavior at the hearing to find the claimant less than credible. *Weaver v. Secretary of Health and Human Servs.*, 722 F.2d 310, 312 (6th Cir. 1983); *Martin v. Secretary of Health and Human Servs.*, 735 F.2d 1008 (6th Cir. 1984) (quoting *Weaver*). However, this rule does not forbid the ALJ from relying in part on his observation of a claimant. "[T]he ALJ may dismiss a claimant's allegations . . . as implausible if the subjective allegations, the ALJ's personal observations, and the objective medical evidence contradict." *Tyra v. Secretary of Health and Human Servs.,* 986 F.2d 1024, 1030 (6th Cir. 1990).

In this case, the ALJ did not base his credibility findings on hearing observation alone, but also on "inconsistencies between [Brimhall's] allegations and the negative findings described in the

medical evidence and . . . inconsistency between the level of severity she described and the low level and infrequent nature of her medical treatment." (R. at 16.) The ALJ cited specific examples of conflicting medical evidence on record and specific examples of conflicts between the plaintiff's testimony and the medical evidence. (*Id.*) Accordingly, it is submitted that the ALJ's credibility determination was based on more than personal observation at the hearing and therefore that the ALJ did not err in concluding that Brimhall's testimony was only partly credible.

In her final challenge to the ALJ's findings, Brimhall contends that the ALJ erred because his decision "tended to minimize the effects of . . . obesity coupled with musculoskeletal degenerative changes." (Brief of Pl. at 10.) Brimhall relies on Social Security Ruling 02-01-P, which notes that symptoms may be exacerbated by obesity and that obesity may trigger additional functional restrictions when it is present in combination with other medical conditions.

The ALJ, however, is obligated only to consider those symptoms that in combination may constitute severe medical disability. 42 U.S.C. § 423(d)(2)(B). Social Security Ruling 02-01-P does not change this standard. To the contrary, it specifically notes that "[t]here is no specific level of weight or BMI [body mass index] that equates with a 'severe' or a 'not severe' impairment . . . we

will do an individualized assessment of the impact of obesity on an individual's functioning." S.S.R. 02-01-P at ¶6. The inquiry remains whether impairments in combination are supported by "signs, symptoms, and laboratory findings" that indicate a severe functional impairment. *See id.* at ¶7. In addition, the ALJ is not required to examine every piece of evidence on the record; it is enough that his decision clearly sets forth a rationale that is clear enough to permit judicial review. *Walker,* 834 F.2d at 643; *Gray v. Comm'r of Soc. Sec.*, Civil Case No. 00-CV-10434-BC, 2001 U.S. Dist. LEXIS 24687, *6 (E.D. Mich. 2001)(unpublished opinion)(citing *Walker*).

In this case, it is submitted that the ALJ correctly considered the effect of obesity in combination with Brimhall's other conditions. He noted that the clinical findings and medical record as a whole "documents only mild degenerative changes and obesity, certainly nothing that would reasonably be expected to render the claimant almost completely unable to stand." (R. at 16.) The ALJ also noted that no treating physician had referred Brimhall to an orthopedist or other specialist of a type that usually would be consulted for problems with walking or standing. (*Id.*) The DDS physicians took note of Brimhall's obesity, (*see, e.g.,* R. at 183), and the ALJ found functional limitations even more restrictive than those suggested by the DDS physicians. (R.

at 17.) In addition, the court notes an absence of long-term or repeated prescriptions for pain medication, and the presence of physicians' recommendations to exercise. (*See, e.g.,* R. at 251 (psychiatrist suggests physical therapy); R. at 30-32, 36-37 (Brimhall's testimony that exercise had been recommended).) Under these circumstances, it is submitted that the ALJ correctly evaluated the impact of Brimhall's obesity on her functioning.

RECOMMENDATION

It is submitted that the ALJ correctly made his determination as to Brimhall's credibility and specifically that the ALJ relied on more than mere personal observation in making that determination; that the ALJ did not err in partially discrediting treating source RFCs based on a lack of underlying clinical and diagnostic records; and that the ALJ correctly considered the combined effects on Brimhall's functional capacity of obesity and other conditions. For the foregoing reasons, it is recommended that substantial evidence supports the ALJ's findings and that the decision of the Commissioner should be affirmed.

Respectfully submitted this 17th day of June, 2003.

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DIANE K. VESCOVO
UNITED STATES MAGISTRATE JUDGE

NOTICE

ANY OBJECTIONS OR EXCEPTIONS TO THIS REPORT MUST BE FILED WITHIN TEN (10) DAYS AFTER BEING SERVED WITH A COPY OF THE REPORT. 28 U.S.C. § (B)(1)(C). FAILURE TO FILE THEM WITHIN TEN (10) DAYS MAY CONSTITUTE A WAIVER OF OBJECTIONS, EXCEPTIONS, AND FURTHER APPEAL.