

**UNITED STATES DISTRICT COURT  
NORTHERN DISTRICT OF INDIANA  
HAMMOND DIVISION**

DONALD P. SANTINO	)	
	)	
Plaintiff,	)	
	)	
v.	)	CAUSE NO.: 2:06-CV-75-PRC
	)	
MICHAEL J. ASTRUE,	)	
Commissioner of the Social Security	)	
Administration, <sup>1</sup>	)	
	)	
Defendant.	)	

**ORDER**

This matter is before the Court on a Complaint [DE 1], filed by the Plaintiff, Donald P. Santino, on March 1, 2006, and on Plaintiff’s Motion for Summary Judgment [DE 17], filed on July 17, 2006. The Plaintiff seeks judicial review of a final decision of the Commissioner, by which he was denied disability insurance benefits under the Social Security Act. The Plaintiff seeks review pursuant to 42 U.S.C. § 405(g). For the following reasons, the Court grants the Plaintiff’s request to reverse and remand the case for further proceedings before the ALJ.

---

<sup>1</sup> On February 12, 2007, Michael J. Astrue became the Commissioner of the Social Security Administration. Pursuant to Federal Rule of Civil Procedure 25(d)(1) and the last sentence of 42 U.S.C. § 405(g), Michael J. Astrue is automatically substituted as the Defendant in this civil action.

## **PROCEDURAL BACKGROUND**

On August 23, 2000, the Plaintiff applied for Disability Insurance Benefits ("DIB"), alleging disability since July 1, 1998. The Plaintiff's claim for benefits was denied both initially, on November 28, 2000, and upon reconsideration, on April 25, 2001. On May 31, 2001, the Plaintiff requested a hearing before an Administrative Law Judge ("ALJ"). The hearing was conducted on November 20, 2001, in front of ALJ Robert C. Asbille. The Plaintiff appeared in person and by counsel, James Balanoff. In a decision dated April 18, 2002, ALJ Asbille denied Plaintiff's application and found Plaintiff not disabled.

Plaintiff filed a Request for Review of the Hearing Decision on May 31, 2002, and submitted a memo in support of his request. On December 5, 2003, the Appeals Council remanded the case back to the ALJ because it found the ALJ had failed to consider a number of factors bearing on the Plaintiff's alleged symptoms. The Appeals Council also explained that the ALJ had not performed an adequate evaluation of Plaintiff's treating source physician, and had failed to address the non-examining medical source opinions..

A remand hearing was held on November 30, 2004, in Gary, Indiana before ALJ Asbille. Plaintiff appeared at the hearing and James Balanoff appeared as counsel for Plaintiff. Plaintiff's mother, Maryann Wajda, vocational expert Julie Bose, and medical expert Dr. Ashok Jilhewar, also testified at the hearing. The ALJ denied the Plaintiff's claim for disability benefits in a decision dated June 24, 2005. The decision included the following findings:

1. The claimant last met the nondisability requirements for a period of disability and DIB set forth in Section 216(I) of the Social Security Act and was fully insured for such benefits only through March 31, 2004.

2. The claimant has not engaged in substantial gainful activity since the alleged onset of the disability.
3. The claimant has at least one medically determinable impairment which is "severe" within the meaning of the Regulations at 20 CFR §§ 404.1520(c) and 416.920(c).
4. None of the claimant's medically determinable impairments either meet or medically equal the severity level of any of the impairments that are listed in Appendix 1, Subpart P, Regulation NO. 4.
5. The claimant's allegations regarding the severity of his limitations are not totally credible for the reasons set forth in the body of this decision.
6. Since his alleged onset of disability date and continuing through the date of this decision, the claimant has had the ability to lift and carry (push/pull) up to 10 pounds at a time, to sit up to 6 hours of an eight-hour workday, and to stand and walk up to 2 hours of an eight-hour workday, provided he was allowed to shift around in his seat and to stand and walk for no more than 15 minutes at a time with walking limited to no more than 30 yards at a time. However, the claimant has also been limited to performing no more than simple routine tasks since his alleged onset of disability date.
7. The claimant is unable to perform any of his past relevant work (20 CFR § 404.1565 and 416.965).
8. The claimant is a "younger individual" (20 CFR §§ 404.1563 and 416.963).
9. The claimant has a "high school (or high school equivalent) education" (20 CFR §§ 404.1564 and 416.964).
10. The claimant has no transferable skills from any past relevant work (20 CFR §§ 404.1568 and 416.968).
11. The claimant has the residual functional capacity to perform a significant range of sedentary work (20 CFR §§ 404.1567 and 416.967).

12. Although the claimant's exertional limitations do not allow him to perform the full range of sedentary work, using Medical-Vocational Rules 201.27 and 201.18 as a framework for decision-making, there are a significant number of jobs in the national economy that he could perform. Examples of such jobs include work as order clerk (4,500 to 5,000 jobs), sedentary cashier (2,500 to 3,000 jobs) and PBX operator (2,000 to 2,500 jobs).
13. The claimant was not under a "disability" as defined in the Social Security Act, at any time through the date of the decision (20 CFR §§ 404.1520(g) and 416.920(g)).

R. 34-35.

The ALJ ultimately concluded that the Plaintiff's impairments prevented him from performing his past relevant work, but that there were a significant number of sedentary jobs in the national economy that he could perform. Accordingly, the ALJ determined that the Plaintiff was not disabled within the definitions of the Social Security Act and regulations.

On July 19, 2005, the Plaintiff timely requested that the Appeals Council of the Social Security Administration ("SSA") review the ALJ's decision and submitted a memorandum in support of his request on October 14, 2005. On November 30, 2005, the Appeals Council denied his request for review. As a result, the ALJ's decision of June 24, 2005, became the final decision of the Commissioner.

On March 1, 2006, the Plaintiff filed his Complaint in this Court, seeking review of the final decision pursuant to 42 U.S.C. § 405(g) and alleging that the ALJ's decision is not supported by substantial evidence and is premised on errors of law. On May 16, 2006, the Commissioner filed an Answer. On July 17, 2006, the Plaintiff filed a Motion for Summary Judgment and Memorandum in Support of the Motion for Summary Judgment. On November 2, 2006, the Commissioner filed a Memorandum in Support of the Commissioner's Decision, and on November 20, 2006, the Plaintiff filed a Response to the Defendant's Memorandum in Support of the Commissioner's

Decision.

Both parties have consented to have this case assigned to a United States Magistrate Judge to conduct all further proceedings and to order the entry of a final judgment in this case. Thus, this Court has jurisdiction to decide this case pursuant to 28 U.S.C. § 636(c) and 42 U.S.C. § 405(g).

### **FACTS**

The Plaintiff was born on April 9, 1956, and was forty-two (42) years old at the time of the alleged onset of his disability and forty-eight (48) years old at the time of his second hearing. He is 5'10 ½" tall and weighed approximately 279 pounds at the time of his medical consultative examination with Dr. Suresh Mahawar in 2004. The Plaintiff has a General Education Diploma ("GED") and worked as a steel worker from 1980-1997. Because of his alleged back pain and anxiety disorder, the Plaintiff has not performed substantial gainful activity since July 1, 1998.

#### **A. Medical Evidence**

Plaintiff was involved in a motorcycle accident in June of 1996 and has complained of recurring chronic lower back pain since then. A September 25, 1996 X-ray of his lumbar spine revealed minimal decreased height of the L3 vertebra, but the reviewing physician concluded that the deformity was likely the result of an old injury.

On March 1, 1999, he was diagnosed with chronic lower back pain by Dr. Heine Ruiz at the East Chicago Community Health Center. A March 2, 1999, X-ray of his lumbar spine indicated mild straightening and minimal splinting to the right of the lumbar spine consistent with muscle spasms. The X-ray also revealed degenerative arthritic changes and mild to moderate narrowing of

the articular facets from L1 to S1 and mild narrowing of the disc spaces from L1 to L3. Dr. Ruiz also noted a mild old compression fracture deformity of L3 with wedging anteriorly and calcifications of the anterior spinal ligaments at the L2-L3 disc level. In November 1999, Dr. Ruiz provided a medical assessment of Plaintiff's ability to perform work. Dr. Ruiz opined that Plaintiff could lift less than ten pounds occasionally and less than five pounds frequently; stand and walk a total of two hours, a half-hour at a time, and sit a total of four hours, two hours at a time, with two rest breaks of thirty minutes to one hour during an 8-hour work-day. Dr. Ruiz determined that the Plaintiff could occasionally climb and balance, but never stoop, crouch, kneel, or crawl. Dr. Ruiz also opined that Plaintiff must avoid moving machinery, vibrations, and temperature extremes and required two periods of rest in a reclining position lasting between 30 minutes to one hour each. Dr. Ruiz explained that these restrictions resulted from chronic back pain and radiculopathy.

Plaintiff continued seeing Dr. Ruiz through July of 2002, and the doctor continued to treat his lower back pain throughout this period. Dr. Ruiz initially prescribed the Plaintiff Codeine in March of 1999, but the Plaintiff's medication was modified during the course of his treatment with Dr. Ruiz. Plaintiff tried Vioxx, Celebrex, and prescription strength Tylenol 3 to relieve his back pain; however, none of these medications proved to be successful.

In October 2000, Kanayo K. Odeluga, M.D., an internal medicine specialist, examined Plaintiff at the request of the SSA. Plaintiff reported a vertebral fracture from a motorcycle accident in June 1996, degenerative joint disease in the lumbar spine, and anxiety. Dr. Odeluga's examination found mild tenderness over the lumbrosacral segment, a full range of motion, bilateral negative straight leg raise while sitting, though positive on the left leg while supine. Dr. Odeluga found the Plaintiff's condition to be mostly normal, but with symptoms suggestive of neurogenic

claudication with numbness and tingling in the legs. The doctor's overall impression of Plaintiff was that Plaintiff had chronic lower back pain, lumbosacral degenerative disc disease with radicular symptoms, high blood pressure, possible neurogenic claudication and anxiety.

In November 2000, J. Gange, Ph.D., reviewed the record on behalf of the state agency and observed that there was no current treatment for Plaintiff's anxiety. Dr. Gange opined that Plaintiff's anxiety was not severe because it caused only mild restrictions in activities of daily living, social functioning, concentration, persistence, or pace, and there were no episodes of decompensation.

Plaintiff's lower back pain began to spread to his extremities. On November 29, 2000, he complained of pain radiating down his legs to Dr. Ruiz. The pain radiating through Plaintiff's legs was persistent and continued to affect him, causing him difficulty in walking and standing.

In January of 2001, upon a referral from Dr. Ruiz, Plaintiff began seeing Dr. Sam Elghor, a pain specialist at the Center for Pain Management. He visited the facility on three separate occasions until he could no longer afford the treatment due to his lack of insurance and funds. On January 26, 2001, before Plaintiff's first visit, Dr. Elghor completed a "Workfare Medical Form" in compliance with Indiana State Law required for any person who received Township Assistance. In that form, Dr. Elghor opined that Plaintiff is permanently disabled. He indicated that Plaintiff suffered from left sciatica and a compression fracture of the L3 vertebra. Further, he indicated that Plaintiff cannot perform work responsibilities; should avoid lifting or straining more than ten pounds; should avoid repeat bending, stooping, or squatting; should avoid work at heights and overhead; and should avoid fast moving machinery.

On January 29, 2001, Dr. Elghor's examination revealed minimal tenderness in the

paraspinal region, no tenderness with deep palpation of the lumbar spine, no weakness, intact sensation, and equal reflexes. Plaintiff reported back pain radiating down to his left ankle, which Dr. Elghor observed would most likely be due to entrapment of the left L5 nerve root, but he did not prescribe an MRI, because Plaintiff's insurance would not approve it.

Dr. Elghor's notes from Plaintiff's February 5, 2001 visit indicate that social services expressed a willingness to help obtain coverage for a lumbar epidural, but that Plaintiff had stated that he could not arrange for a ride to the hospital and that he was not mentally ready to receive the injection. Plaintiff continued to have difficulty raising his left leg and bending to the left. Dr. Elghor opined that Plaintiff's difficulty walking might be due to entrapment of the left L5 nerve root. On March 19, 2001, Dr. Elghor again referred Plaintiff for a fluoroscopically directed lumbar epidural steroid injection targeted at the L5-S1 interspace on the left side. The record gives no indication that anyone performed the procedure on Plaintiff in 2001.

Plaintiff also suffers from an anxiety disorder which he alleges has a negative affect on his ability to work. Plaintiff's anxiety disorder arose from an incident in which he was attacked in 1997 while working as a pizza delivery person. He began taking the prescription drug Xanax to control his anxiety in 1998 and continues to take the medication presently. On October 21, 1999, Dr. Ruiz prescribed Xanax .5 mg to Plaintiff. Dr. Ruiz continued to prescribe the .5 mg dosage until February 15, 2001, when he increased Plaintiff's Xanax dosage to 1 mg and kept him at this higher dosage throughout the prescription record available.

In January 2002, the Disability Determination Office referred Plaintiff to Mid-America Psychological & Counseling Services, P.C. for a mental status evaluation. Two clinical psychologists, Kalyani Gopal, Ph.D., and Alan S. DeWolfe, Ph.D., interviewed Plaintiff and

conducted a Minnesota Multiphasic Personality Inventory 2 ("MMPI-2") test and Mental Status Examination. Plaintiff displayed mostly normal or adequate behavior. The consultants observed no signs of anxiety or unusual behavior and recorded that Plaintiff reported depression from his back pain. The results of the MMPI-2 inventory indicated a significant elevation on Scale 1, which is Hypochondriasis (Anxiety/Obsessive Compulsive Disorder) and Scale 2, which is Depression. The doctors diagnosed early onset of dysthmic disorder and assigned a GAF score of 65. The consultants opined that Plaintiff's mental impairment caused no substantial limitations on his ability to perform work-related tasks.

In September 2002, David Chube, M.D., a family practice physician, became Plaintiff's primary care physician, and regularly treated Plaintiff throughout the remainder of the relevant period. Plaintiff related to Dr. Chube a history of compression fractures, sciatica, and anxiety, and Dr. Chube began prescribing medication.

In February 2003, Plaintiff went to Tri-City counseling, but his case was closed in May 2003, after no treatment.

In April 2004, Suresh Mahawar, M.D., examined Plaintiff at the request of the Agency. Plaintiff reported that he had been diagnosed with fractured vertebra, herniated disc, compression fracture, and sciatic nerve. An x-ray of Plaintiff's lumbar spine revealed mild degenerative changes with narrowing at L1-L2, and L2-L3. Dr. Mahawar's examination revealed mostly normal findings, including a full range of motion, full strength, no signs of atrophy, bilateral negative straight leg testing, normal gait, no difficulty getting on and off the examination table or tandem walking, and only mild difficulty walking on toes and heels, squatting, and hopping. Dr. Mahawar opined that Plaintiff could lift 50 pounds occasionally, and 25 pounds frequently; stand and walk 2 hours in an

8-hour work-day; sit without restriction; frequently balance; occasionally climb, kneel, crouch, crawl, and stoop; and that he was limited with respect to working around dust, vibration, humidity, and fumes. The doctor ultimately diagnosed Plaintiff with low back pain with disc degeneration and some evidence of compression fracture.

In July 2004, Dr. Chube provided a medical assessment of Plaintiff's ability to perform work. Dr. Chube opined that Plaintiff could lift less than five pounds occasionally; stand and walk a total of two hours, two hours at a time, and sit a total of six hours, two hours at a time during an 8-hour work-day; occasionally balance, but never push, pull, climb, stoop, crouch, kneel, or crawl. Dr. Chube also opined that Plaintiff required at least two periods of rest in a reclining position lasting less than 30 minutes. Dr. Chube opined that these restrictions resulted from cervical radiculopathy, a compression fracture at S5, and Lumbar compression at L3 and L4.

Later in December 2004, Plaintiff reported to Tri-City with a request for counseling. The Tri-City staff noted that Plaintiff had been treated for alcohol abuse following a DUI in 1992 and referred more recently in 2002. Plaintiff began counseling and continued sessions through February 2005.

On January 22, 2005, Shashi Anand, Ph.D., performed a psychological evaluation per the ALJ's request. Plaintiff displayed mostly normal or adequate behavior. Dr. Anand diagnosed a history of alcohol abuse and adjustment disorder with depressed mood and assigned a GAF score of 74. Dr. Anand opined that Plaintiff's mental impairments did not limit his ability to perform work-related tasks.

Four days later, on January 27, 2005, a mental health professional at Tri-City interviewed Plaintiff. The counselor diagnosed a history of alcohol abuse and adjustment disorder with

depressed mood and assigned a GAF score of 50 to 55. The counselor offered no opinion as to Plaintiff's work-related limitations.

On April 21, 2005, Plaintiff visited St. Catherine's Hospital where Dr. Spotwood performed an MRI. The MRI revealed arthritic changes of the facet joints and hypertrophy of the ligamentum flavum. Dr. Spotwood also noted mild universal stenosis at the L3-L4 and L4-L5 levels as well as mild universal bulging of the L1-L2 and L3-L4 intervertebral discs. The doctor's report mentions the presence of Schmorl's nodes in multiple lumbar vertebral bodies. Plaintiff returned to St. Catherine's on April 29, 2005, and Dr. Spotwood performed an electromyography. The electromyography revealed mild to moderate foraminal encroachment, notably on the right L5-S1 paraspinal root level. Dr. Spotwood opined that the arthropathy may be affecting the L3-4 and 4-5 paraspinal root levels.

Three days after the ALJ's June 24, 2005 decision denying Plaintiff benefits, Plaintiff returned to St. Catherine's Hospital for a caudal epidural steroid injection with epidurogram and neurogram by Dr. Tarek Shahbandar. Dr. Shahbandar diagnosed Plaintiff with lumbar spinal stenosis and lumbar radiculopathy. Plaintiff reported mild reduction in pain after the procedure and scheduled a follow-up appointment with the doctor for two weeks later. On July 7, 2005, during his follow-up appointment with Dr. Shahbandar, Plaintiff reported that the injection and medications had made very little difference in what he could do, his quality of life, and experience of constant pain.

### **B. Plaintiff's Testimony**

At the first hearing, on November 2, 2001, Plaintiff testified that he is single, right-handed, and lives with his mother and sister in a house in East Chicago, Indiana. Plaintiff testified that he completed school through the tenth grade and then acquired a GED. Between 1980 and 1997 Plaintiff was employed as a steel worker, and between 1997 and July 1, 1998, he was working for temporary agencies until he became disabled. Plaintiff stated that he left the steel mill in order to find a job that was less physically demanding. During the time between leaving the steel mill and when he became allegedly disabled, Plaintiff worked for a friend and had a range of responsibilities, including warehouse work, deliveries, and answering telephones/taking orders.

Plaintiff testified at the hearing that he was currently seeing Dr. Ruiz on a regular basis. He stated that the medications he had been taking had not alleviated his physical pain, and that he needs to get steroid injections, but that he does not have the appropriate insurance or means to be able to do so. He testified that he has several cracked vertebra and that the pain in his back is persistent and is exasperated by walking any distance. As a result, Plaintiff testified that climbing stairs is extremely difficult and may be among the most difficult of tasks that he has to do. Furthermore, Plaintiff has great difficulty sleeping and on a good day, will sleep only four hours. Plaintiff testified that his ability to lift an object is based on whether his back will allow him to do so.

Plaintiff testified that he has severe anxiety and depression related problems. He further testified that he cannot explain the anxiety very well and that it is not only triggered by flashbacks of when he was robbed at gunpoint, but also by situations in which he feels uncomfortable. He testified that he cannot explain the feeling very well, but that it is a bad feeling he begins to feel when certain situations occur. He stated that his anxiety-condition has a negative affect on his

ability to work because he tightens up and may experience a panic attack when someone gives him orders or when people are rude toward him.

Plaintiff testified that even when he is physically able to get out of the house, his anxiety condition can easily preclude him from doing so. Plaintiff testified that he does a few menial chores around the house including taking the garbage out and washing his laundry, but that he is not able to do much more due to his physical condition. Plaintiff testified that he does not get out very often because he cannot walk, and in the last month he has been able to walk only as far as his neighbor's house, which is about 20-25 feet away.

During a second hearing on November 30, 2004, Plaintiff testified that he was disabled due to chronic back pain and pain in his left leg. Before the onset of his alleged disability, the Plaintiff worked as a steel worker for nearly seventeen years. In the summer of 1996, Plaintiff fell from a motorcycle, which he explained resulted in two fractured vertebrae, a herniated disc and a compression fracture. Plaintiff testified that he attempted to work as a pizza delivery person after his fall, but stopped delivering pizzas after an incident in which he was beaten and robbed in the Spring of 1997. As a result of the incident, Plaintiff testified that he also has difficulty with anxiety and panic attacks.

Plaintiff testified that his main problem is that he is in constant pain. He explained that he is unable to do anything repetitious like vacuuming or scrubbing floors and that he is also unable to perform sedentary work because he needs to be able to get up to stretch his legs. He further testified that he spends most of the day lying down with his leg propped up on a pillow because that is how he feels most comfortable. Plaintiff described his symptoms in his left leg as alternate numbness and pain. He stated that his condition has caused him to fall out of the bathtub, fall down

stairs, have difficulty walking and balancing, and also hit his head. He also explained that he has difficulty sitting or standing for long periods of time and trouble with stiffness in his neck, but that he is able to use his hands without difficulty. The Plaintiff also alleged that he has been having frequent back spasms and that once the pain starts in his leg, he often has trouble bending and twisting with his spine. The Plaintiff explained that he does not use a cane because he cannot afford one and has never asked his doctor about using a cane. He further explained that he has had difficulty obtaining medical treatment due to lack of funds and insurance.

The Plaintiff testified that he also has significant difficulties with anxiety. He claimed that he has panic attacks, becomes paranoid, and is unable to talk with other people. He explained that his anxiety problems worsened considerably after he was beaten and robbed while working as a pizza delivery person and that he did not leave his apartment at night for several years after the incident occurred.

The Plaintiff further testified that he has difficulty sleeping and has constant nightmares. He clarified that he did not feel like hurting himself, but that he frequently felt hopeless and had poor memory and concentration. The Plaintiff also testified that at times his pain and anxiety seemed to be interconnected in that pain would cause him to be unable to do things and as a result, he would feel overwhelmed with feelings of uselessness and hopelessness. The Plaintiff and his attorney explained that some of the Plaintiff's symptoms were likely due to his medications and that the number of medications he was taking made it difficult for him to obtain mental health services from local clinics. The local clinics required medical detox if there was any indication of a substance abuse problem.

The Plaintiff testified that Dr. Ruiz prescribed Tylenol for him for three and a half years and

wanted to refer his care to the pain management specialists at St. Catherine's Hospital. Because Plaintiff was contemplating elective surgery, he needed to provide a certain amount of funds before he could have the surgery. Plaintiff testified that because he was unable to come up with the necessary funds, the pain management specialists were unwilling to treat him. Plaintiff then began seeing Dr. Chube, who agreed to treat him pending his Medicaid case. At the time of his June 2005 hearing with the ALJ, the Plaintiff had not had any MRIs or CT scans due to his limited financial resources. The Plaintiff explained that Dr. Chube had provided him with medicine and observation, but no other treatment.

### **C. Testimony of the Plaintiff's Mother**

Plaintiff's mother, Maryann Wajda, also testified at the hearing. She testified that the Plaintiff lived with her and her daughter. She confirmed that Plaintiff often appeared to be sleepless and that he had frequent nightmares. She explained that she was aware of Plaintiff's condition because he would tell her about it and also because he appeared most mornings with dark circles under his eyes, looking as if he had not slept. She was also able to recall an incident of Plaintiff falling down stairs and mentioned that his right leg kept giving out on him.

Ms. Wadja testified that she was unaware of the pizza delivery incident until months after it had occurred because Plaintiff had not told her about it. She explained that he had tried to work after the incident but simply couldn't because of his back pain. She confirmed that Plaintiff was often very nervous and that she believed he had gotten the trait from her. She also testified that Plaintiff's irritability had increased since he had been out of work. Ms. Wadja explained that Plaintiff did very little in a day because of his physical limitations. She stated that he usually read the paper, watched television, and ate. She stated that the Plaintiff also rested for significant

amounts of time. She could not be certain that he was actually sleeping because he usually retired to his room and closed the door, but she thought that he spent the time lying down. She testified that Plaintiff would become very emotional, nervous and upset whenever he needed to go somewhere. She explained that he would pace back and forth constantly and make himself a nervous wreck. When the ALJ asked her if Plaintiff had difficulty talking to others, Mrs. Wadja replied that she thought that Plaintiff needed another person to talk to besides herself and her daughter.

Mrs. Wadja testified that she was currently the sole support for both Plaintiff and her daughter. She explained that she had tried to help Plaintiff obtain medical treatment, but had been unable to do so recently because she had been very ill herself.

#### **D. Testimony of the Medical Expert**

A medical expert, Dr. Ashok Jilhewar, also testified at the second hearing. Dr. Jilhewar summarized Plaintiff's impairments, noting that the Plaintiff had been diagnosed with mechanical lumbar spine pain as early as 1997, but that there did not appear to be any findings of neurological problems or weakness at that time. Dr. Jilhewar noted that Plaintiff's October 2000 consultative examination did not include objective findings to explain Plaintiff's pain and that Dr. Elghor's 2001 examination of Plaintiff also revealed a similar lack of objective findings that would explain Plaintiff's pain. The doctor explained that on a straight leg raise test, 90 was normal and a 70, reflected in Dr. Elghor's findings in regard to Plaintiff, indicated only a mild condition. Dr. Jilhewar noted that Dr. Elghor's records indicated Plaintiff had pain and cramping in his left leg after walking thirty yards, but that Dr. Elghor's exam indicated no weakness, limping or abnormality in Plaintiff's reflexes.

Dr. Jilhewar stressed the absence of objective medical evidence to explain Plaintiff's pain

and explained that while the March 1999 X-ray of Plaintiff's spine indicated the presence of spasm of the lumbar muscles, such a spasm had never been documented in a clinical exam. The doctor also pointed out that Plaintiff's 2004 consultative examination yielded no more objective medical findings to explain his pain than his treating physician's evaluation in 2001.

Dr. Jilhewar acknowledged Plaintiff's anxiety, but pointed out there was very little clinical evidence of Plaintiff's anxiety. He also noted that Plaintiff is overweight, but clarified that Plaintiff was not morbidly obese and that neither Plaintiff's anxiety or weight were severe enough to meet the listings in 1. 04(c) or (a) due to the lack of objective findings.

Dr. Jilhewar concluded that Plaintiff was limited to sedentary work, could lift 10 pounds occasionally, five pounds frequently, sit for at least six hours in an eight-hour day as long as he could shift positions, stand for a total of two hours in an eight-hour day in fifteen-minute increments, and walk no more than thirty yards. Dr. Jilhewar testified that he could not know the severity of Plaintiff's anxiety on the available record, but thought that it would be enough to reduce Plaintiff's functional capacity from light work to sedentary work.

Dr. Jilhewar clarified his impressions from the record by explaining that a compression fracture at the L3 vertebra could cause numbness in the upper thigh, but not a person's entire leg. Dr. Jilhewar also opined that an X-ray was insufficient to identify sources of pain because in his experience, some patients can have pain with no X-ray findings and others can show damage on an X-ray and yet, have no experience of pain.

Dr. Jilhewar criticized the fact that Plaintiff's treating physician had prescribed Xanax for him because Xanax causes dependency and can also cause nightmares when patients who take it start to go through withdrawal. Dr. Jilhewar testified that Xanax actually worsens anxiety problems.

The doctor confirmed that he could not judge Plaintiff's psychological condition with certainty, but that if the Plaintiff had a less severe psychological condition than that suggested by the record, the Plaintiff could perform light work, and if the Plaintiff's psychological condition was worse than that suggested by the record, the Plaintiff might only be able to perform a limited range of sedentary work.

#### **E. Testimony of the Vocational Expert**

Vocational expert Julie Bose testified at the hearing and classified the Plaintiff's past work experience. Ms. Bose stated that the Plaintiff's past relevant work as a steel worker was medium with physical demand and unskilled in nature, and that his brief work as a day laborer was also medium and unskilled. Because Plaintiff's pizza delivery job had lasted less than a month, Ms. Bose did not include it in her classifications.

The ALJ then asked Ms. Bose to consider a claimant with the Plaintiff's age, education, and vocational background who was limited to sedentary work that permitted claimant to change position in his seat, where he would be required to walk and stand no more than a total of two out of eight hours, for a maximum of fifteen minutes at a time, walk no more than thirty yards and perform only simple, routine tasks. Ms. Bose responded that the individual could not return to any of his past relevant work, but that such a claimant's limitations would not rule out clerical, service and manufacturing work. Due to the claimant's sit/stand limitation, Ms. Bose thought that the service-oriented positions would be best for the claimant. She testified that in Northwest Indiana and the Chicago metropolitan area, such positions include order clerk (4,500 – 5,000 jobs), sedentary cashier (2,500 - 3,000 jobs), and PBX or call out operator (2,000 – 2,500 jobs). Ms. Bose opined that the hypothetical claimant could also perform work in bench assembly, as a bench sorter, or

bench packer, but that the number of jobs in those categories would be reduced due to the claimant's non-exertional limitations.

The ALJ then posed the hypothetical of a claimant that needed to rest all day because of pain. Ms. Bose responded that such a claimant would be unable to work.

Attorney Balanoff then asked Ms. Bose if a claimant would be able to work in the positions she listed if the claimant, due to pain and anxiety, had difficulty concentrating on simple, routine tasks. Ms. Bose responded that such a claimant would not. Attorney Balanoff then asked Ms. Bose if a claimant would be precluded from performing the jobs she had listed if the claimant was prone to fall due to numbness in one leg. Ms. Bose responded that it would depend on how frequently the claimant tended to fall, that she had listed jobs that involved very little walking, and that a tendency to fall might reduce the number of jobs among the ones she had listed, but not eliminate them.

#### **F. The ALJ's Decision**

Because there had been virtually no change in the Plaintiff's work status or physical impairments from the date of the Plaintiff's first hearing, the ALJ accepted the recitation of evidence and applicable regulations shown in the first hearing with respect to the Plaintiff: (a) having not engaged in substantial gainful activity at any time during at least the one year period following his alleged onset of disability date and (b) having at least one medically determinable impairment which meets the regulatory definition of impairment. In his prior opinion, the ALJ had found that Plaintiff had not engaged in substantial gainful work as defined in 20 C.F.R. 404.1572 since his alleged onset date. In his first opinion, the ALJ had also found that the Plaintiff was impaired by disorders of the back and osteoarthritis and that the impairment was severe under the standards of the Social Security Act and accompanying regulations, but yet not severe enough to meet or medically equal one of the

impairments listed in Appendix 1, Subpart P, Regulations No. 4.

In evaluating the severity of Plaintiff's physical impairments, the ALJ considered the medical evidence from Plaintiff's treating physicians, Dr. Ruiz and Dr. Chube. The ALJ noted that Dr. Chube did not document the results of any physical exam he may have performed on the Plaintiff, and had also failed to submit any radiological evidence to support his medical opinion that Plaintiff was suffering from cervical radiculopathy, a compression fracture at L5, and a lumbar compression at L4. The ALJ also considered the report from the 2004 consultative examination performed by SSA doctor Suresh Mahawar. Ultimately, the ALJ agreed with Dr. Jilhewar's testimony, that the Plaintiff's physical impairments did not meet or medically equal the impairments listed in Appendix 1, Subpart P, Regulations No. 4.

In evaluating the severity of Plaintiff's mental impairments, the ALJ considered the 2000 report from DDS consulting physician Kanayo Odeluga, who diagnosed the Plaintiff with anxiety even though the Plaintiff had not exhibited symptoms of anxiety during his exam. The ALJ also considered the 2002 opinion of consulting psychologists Drs. Kalyani Gopal and Alan S. DeWolfe, who reported that the Plaintiff had only mild depression, mainly attributable to back pain. The ALJ found Drs. Gopal's and DeWolfe's diagnosis of early onset dysthymic disorder with a Global Assessment of Functioning (GAF) rating of 65 out of 100 consistent with those of the DDS medical consultant who had reviewed Dr. Odeluga's report and found Plaintiff's anxiety "not severe." R. 28.

In order to obtain more information about Plaintiff's mental condition, the ALJ had referred the Plaintiff to clinical psychologist Shashi Anand, who performed a mental evaluation in 2005. Dr. Anand diagnosed Plaintiff as having a history of alcohol abuse and a history of adjustment disorder

with depressed mood. He assigned the Plaintiff a GAF of 74 out of 100 and opined that Plaintiff's mental condition would not affect his ability to work.

The ALJ also considered records from Tri-City Mental Health Center where Plaintiff had sought treatment and a January 2005 evaluation by a Health City psychiatrist who affirmed the earlier diagnosis of generalized anxiety disorder and adjustment disorder with depressed mood and a history of alcohol abuse. The Health Center psychiatrist assigned Plaintiff a GAF rating of 50-55.

The ALJ acknowledged that the findings of the Health Care psychologist conflicted with the findings of Dr. Anand, who had interviewed Plaintiff only five days before, but found that Plaintiff's mental impairments were not severe and caused no more than mild limitations on his daily living, ability to maintain social functioning, and ability to maintain concentration, persistence, and pace. The ALJ also found that Plaintiff's anxiety had not caused him to have any episodes of decompensation.

When the ALJ determined Plaintiff's RFC, the ALJ considered the Plaintiff's testimony as well as that of his mother. The ALJ noted that Dr. Odeluga in 2000 and Dr. Elghor in 2001, both found that Plaintiff had tenderness in the paraspinal region, but that neither doctor found the Plaintiff to be limited in terms of range of motion or found evidence of nerve root impingement, compression or radiculopathy. Conversely, the ALJ noted that treating physician Dr. Ruiz did find the Plaintiff to have chronic back pain with radiculopathy. However, the ALJ also considered the fact that Dr. Ruiz had recommended an MRI and other testing and evaluation, none of which were ever performed.

The ALJ further considered Dr. Mahawar's consultative examination in which Dr. Mahawar put very few restrictions on Plaintiff except that Plaintiff's ability to stand and walk was limited to two hours in an eight-hour day. The ALJ rejected Dr. Chube's conclusions that Plaintiff had

cervical radiculopathy, a compression fracture at L5, and lumbar compression at L3-4. The ALJ also rejected Dr. Chube's opinion that Plaintiff's physical impairments limited him to standing and walking for no more than one hour in an eight-hour day and sitting for no more than six hours in an eight-hour day in two-hour increments with rest breaks in the reclining position for less than 30 minutes. The ALJ explained that Dr. Chube's impressions were not born out by the objective medical evidence or Dr. Chube's own treatment records.

The ALJ concluded his assessment of the various medical source opinions in the record by voicing his agreement with Dr. Jilhewar's opinions and testimony. The ALJ found that Plaintiff has the ability to lift and carry (push/pull) up to ten pounds at a time, to sit up to six hours in an eight-hour day provided he is allowed to shift in his seat, and to stand and walk up to two hours in an eight-hour day for fifteen minutes at a time, with walking limited to thirty yards at a time. The ALJ also found that due to Plaintiff's chronic pain, the Plaintiff had sustained a mild loss of the ability to maintain concentration and attention, which affected his ability to perform complex or detailed work. The ALJ limited the claimant to sedentary work that required no more than simple, routine tasks. The ALJ did not wholly reject the opinions of the physicians who had placed more severe limitations on Plaintiff, but rather, found that the Plaintiff's ability to shift in his seat should make it possible for him to perform sedentary work. Due to the overwhelming evidence that Plaintiff should perform only sedentary work, the ALJ rejected the opinion of the DDS reviewing physician who found Plaintiff's impairments "not severe." R. 32.

The ALJ found Plaintiff's testimony regarding the impact of his mental status on his ability to work only partially credible because the Plaintiff's reports of mental health problems were significantly worse than those of the mental health professionals who observed him. The ALJ accepted that the Plaintiff should be limited to sedentary work and further limited the Plaintiff to

only simple, routine tasks due to Plaintiff's chronic pain as opposed to any mental impairment.

The ALJ concurred with Ms. Bose's opinion that because the Plaintiff was limited to sedentary work, he was therefore incapable of performing any past relevant work. The ALJ also found that Plaintiff is a "younger individual" pursuant to C.F.R. 404.1563 and that he had obtained a GED. Based upon the Plaintiff's work history, the ALJ found that the Plaintiff had not acquired any transferable skills from his past relevant work.

Pursuant to the Plaintiff's Residual Functional Capacity, the ALJ found that the Plaintiff has been capable of performing a significant range of sedentary work, as defined at 20 C.F.R. §§ 404.1567 and 416.967. The ALJ explained that the hypothetical he posed to vocational expert Ms. Bose had incorporated the limitations of Plaintiff's RFC. Ms. Bose had responded that there were a significant number of sedentary jobs in the economy that Plaintiff could perform. Consequently, the ALJ concluded that Plaintiff was not under a disability as defined in the Social Security Act.

### **STANDARD OF REVIEW**

The Social Security Act authorizes judicial review of the final decision of the agency and indicates that the Commissioner's factual findings must be accepted as conclusive if supported by substantial evidence. 42 U.S.C. § 405(g). Thus, a court reviewing the findings of an ALJ will only reverse if the findings are not supported by substantial evidence or if the ALJ has applied an erroneous legal standard. *See Clifford v. Apfel*, 227 F.3d 863, 869 (7th Cir. 2000). Substantial evidence consists of "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales*, 402 U.S. 389, 401 (1971); *Schmidt v. Barnhart*, 395 F.3d 737, 744 (7th Cir. 2005) (quoting *Gudgel v. Barnhart*, 345 F.3d 467, 470 (7th Cir. 2003)).

A court reviews the entire administrative record but does not reconsider facts, re-weigh the

evidence, resolve conflicts in evidence, decide questions of credibility, or substitute its judgment for that of the ALJ. *See Boiles v. Barnhart*, 395 F.3d 421, 425 (7th Cir. 2005); *Clifford*, 227 F.3d at 869; *Butera v. Apfel*, 173 F.3d 1049, 1055 (7th Cir. 1999). Thus, the question upon judicial review of an ALJ's finding that a claimant is not disabled within the meaning of the Social Security Act is not whether the claimant is, in fact, disabled, but whether the ALJ's findings are supported by substantial evidence and under the correct legal standard. *See Lopez v. Barnhart*, 336 F.3d 535, 539 (7th Cir. 2003); *Schmidt v. Apfel*, 201 F.3d 970, 972 (7th Cir. 2000). If an error of law is committed by the Commissioner, then the "court must reverse the decision regardless of the volume of evidence supporting the factual findings." *Binion v. Chater*, 108 F.3d 780, 782 (7th Cir. 1997).

An ALJ must articulate, at a minimum, his analysis of the evidence in order to allow the reviewing court to trace the path of his reasoning and to be assured that the ALJ considered the important evidence. *See Scott v. Barnhart*, 297 F.3d 589, 595 (7th Cir. 2002); *Diaz v. Chater*, 55 F.3d 300, 307 (7th Cir. 1995); *Green v. Shalala*, 51 F.3d 96, 101 (7th Cir. 1995). The ALJ is not required to address "every piece of evidence or testimony in the record, [but] the ALJ's analysis must provide some glimpse into the reasoning behind [the] decision to deny benefits." *Zurawski v. Halter*, 245 F.3d 881, 888 (7th Cir. 2001). The ALJ must build an "accurate and logical bridge from the evidence to his conclusion so that, as a reviewing court, we may assess the validity of the agency's ultimate findings and afford a claimant meaningful judicial review." *Young v. Barnhart*, 362 F.3d 995, 995 (quoting *Scott*, 297 F.3d at 595); *see also Hickman v. Apfel*, 187 F.3d 683, 689 (7th Cir. 1999) (citing *Sarchet v. Chater*, 78 F.3d 305, 307 (7th Cir. 1996)).

### **DISABILITY STANDARD**

To be eligible for disability benefits, a claimant must establish that he suffers from a "disability" as defined by the Social Security Act and regulations. The Act defines "disability" as an inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that 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). To be found disabled, the claimant's impairment must not only prevent him from doing his previous work, but considering his age, education, and work experience, it must also prevent him from engaging in any other type of substantial gainful activity that exists in significant numbers in the economy. 42 U.S.C. § 423(d)(2)(A); 20 C.F.R. § 404.1520(e), (f).

When a claimant alleges a disability, Social Security regulations provide a five-step inquiry to evaluate whether the claimant is entitled to benefits. 20 C.F.R. § 404.1520(a)(4). The steps are:

- (1) Is the claimant engaged in substantial gainful activity? If yes, the claimant is not disabled, and the claim is denied; if no, the inquiry proceeds to Step 2.
- (2) Does the claimant have an impairment or combination of impairments that are severe? If not, the claimant is not disabled, and the claim is denied; if yes, the inquiry proceeds to Step 3.
- (3) Does the impairment(s) meet or equal a listed impairment in the appendix to the regulations? If yes, the claimant is automatically considered disabled; if not, then the inquiry proceeds to Step 4.
- (4) Can the claimant do the claimant's past relevant work? If yes, the claimant is not disabled, and the claim is denied; if no, then the inquiry proceeds to Step 5.
- (5) Can the claimant perform other work given the claimant's residual functional capacity, age, education, and experience? If yes, then the claimant is not disabled, and the claim is denied; if no, the claimant is disabled. 20 C.F.R. §§ 404.1520(a)(4)(I)-(iv); *see also Scheck v. Barnhart*, 357 F.3d 697, 699-700 (7th Cir. 2004).

At the fourth and fifth steps, the ALJ must consider an assessment of the claimant's RFC.

"The RFC is an assessment of what work-related activities the claimant can perform despite [his]

limitations." *Young*, 362 F.3d at 1000. The ALJ must assess the RFC based on all the relevant evidence of record. *Id.* at 1001 (citing 20 C.F.R. § 404.1545(a)(1)). The claimant bears the burden of proving steps one through four, whereas the burden at step five is on the ALJ. *Id.* at 1000; *see also Zurawski*, 245 F.3d at 886; *Knight v. Chater*, 55 F.3d 309, 313 (7th Cir. 1995).

### **ANALYSIS**

The Plaintiff claims that the ALJ erred by finding he was not disabled within the meaning of the Social Security Act and by denying him disability benefits. Plaintiff asserts the following arguments in support of his claim: (1) the ALJ failed to follow SSR 98-6p and incorporate all of Plaintiff's limitations into the RFC analysis; (2) the ALJ failed to properly evaluate Plaintiff's mental impairments and incorporate them into his RFC finding ; (3) the ALJ made an improper credibility finding that ignores SSR 96-7p and 20 C.F.R. § 404.1527; and (4) the ALJ's Step Five decision is erroneous.

#### **A. RFC**

The Plaintiff contends that the ALJ committed harmful error by making an erroneous and incomplete RFC assessment. Specifically, the Plaintiff argues that the ALJ failed to follow SSR 96-8p because he failed to evaluate how Plaintiff's combined impairments affect his ability to work properly. Additionally, the Plaintiff argues that the ALJ did not properly incorporate the effect of Plaintiff's mental impairments in his decision, that he failed to perform a mental RFC determination, and that he ignored the effect of Plaintiff's obesity on his impairments. The Plaintiff also argues that the ALJ failed to perform a function-by-function analysis of Plaintiff's impairments pursuant to SSR 96-8p.

*1. Weight of a treating physician's opinion*

As part of his argument, the Plaintiff asserts that the ALJ erred in rejecting the limitations given by Plaintiff's primary treating physicians Drs. Ruiz and Chube. As a result, the Plaintiff claims that the ALJ made an erroneous and incomplete assessment of Plaintiff's RFC.

In assessing disability, the ALJ generally gives more weight to the opinion of a source who has examined the claimant rather than to the opinion of a non-examining source. *See* 20 C.F.R. 404.1527(d)(1). The ALJ must give a treating physician's opinion controlling weight if it is well supported by medical findings and is not inconsistent with the substantial evidence in the record. *See* 20 C.F.R. 404.1527(d)(2); SSR 96-2p; *Hofslien v. Barnhart*, 439 F.3d 375, 376 (7<sup>th</sup> Cir. 2006); *White v. Barnhart*, 415 F.3d 654, 658 (7<sup>th</sup> Cir. 2005). In assessing disability, more weight is given to the opinion of a treating physician because of the greater familiarity with a claimant's conditions and circumstances. *See Gudgel v. Barnhart*, 345 F.3d 467, 470 (7<sup>th</sup> Cir. 2003). In order to meet the qualifications of a "treating physician" under the regulations, the doctor "must provide a detailed, longitudinal picture of Plaintiff's impairments" or bring a "unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from the reports of individual examination." 20 C.F.R. 404.1527(d)(2), 416.927(d)(2).

Where a medical opinion is not supported by objective medical findings and is inconsistent with other record evidence, the ALJ is not required to accept that medical opinion or incorporate it into his findings. *See* 20 C.F.R. 404.1527(d)(3)-(4), 416.927 (d)(3)-(4). When the ALJ does not give the treating physician's opinion controlling weight, the ALJ applies the following factors in evaluating the opinion: length of treatment, the nature and extent of the treating relationship, to what

extent the treating physician based his or her opinion on evidence such as medical signs and laboratory findings, how consistent the treating physician's opinion is with the record, whether the treating physician is a specialist and any other relevant factors. *See* 20 C.F.R. § 404.1527(d)(2).

The ALJ's opinion indicates that the ALJ considered the Plaintiff's testimony, the opinions of consultative examining physicians Drs. Odeluga and Mahawar, and the opinions of all three of Plaintiff's treating physicians, Drs. Ruiz, Elghor, and Chube. In order to resolve the conflicting medical opinions, the ALJ also asked medical expert Dr. Jilhewar to review the evidence in the record and to testify as to his opinion regarding Plaintiff's RFC.

The ALJ is not obligated to give a treating physician's opinion controlling weight unless the opinion is both "well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with other evidence in [the claimant's] case record." 20 C.F.R. § 404.1527(d)(2); SSR 96-2p. When the ALJ rejected treating physician Dr. Chube's opinion, he explained that Dr. Chube's proposed restrictions were not supported by objective medical evidence or by his own treatment records. Earlier in his opinion, the ALJ specifically criticized Dr. Chube's opinion because Dr. Chube's treatment notes did not document the results of any physical exam he may have performed on the Plaintiff. Additionally, the ALJ expressed skepticism at Dr. Chube's opinion because Dr. Chube had not submitted any radiological evidence to support his opinion that Plaintiff was suffering from cervical radiculopathy, a compression fracture at L5 and a lumbar compression at L3-4. Because the ALJ found that Dr. Chube's opinion was not supported by objective medical findings and was inconsistent with other record evidence, the ALJ was not required to accept Dr. Chube's medical opinion or incorporate it into his findings. *See* 20 C.F.R. 404.1527(d)(3)-(4), 416.927 (d)(3)-(4).

In evaluating Dr. Ruiz's opinion, the ALJ noticed that both Drs. Odeluga and Elghor had

found tenderness in Plaintiff's paraspinal region, but no significant limits on Plaintiff's range of motion and no objective evidence of nerve root impingement, compression or radiculopathy. Conversely, Dr. Ruiz had specifically diagnosed Plaintiff with chronic lower back pain with radiculopathy, a position the ALJ found inconsistent with Dr. Odeluga and Dr. Elghor's findings. However, the ALJ failed to mention that Dr. Odeluga's opinion included the final impression that Plaintiff had lumbosacral degenerative disc disease with radicular symptoms.

Similarly, the ALJ acknowledged that Dr. Ruiz's opinion that Plaintiff could sit for no more than four hours in an eight-hour work day for up to two hours at one time conflicted with Dr. Jilhewar's conclusion that Plaintiff could sit for six hours in an eight-hour work day. The ALJ did not discredit Dr. Ruiz's opinion as quickly as Dr. Chube's, because unlike Dr. Chube's opinion, Dr. Ruiz's opinion was supported by some objective medical evidence. The ALJ also noted that Dr. Ruiz had reported that Plaintiff needed to undergo further treatment, none of which Plaintiff underwent while Dr. Ruiz was treating him. However, the ALJ did not indicate that Plaintiff's failure to undergo further treatment was a basis for rejecting Dr. Ruiz's opinion.

Ultimately, the ALJ concluded that Dr. Jilhewar's assessment of the Plaintiff was the most practical and determined that if the Plaintiff had the ability to shift in his seat, he would be able to sit for up to six hours total in an eight-hour day. Of concern to this Court is that when the ALJ explained his reasoning for adopting Dr. Jilhewar's opinion, he stated merely that he failed to see the difference between sitting for four hours and sitting for six hours when the Plaintiff has the ability to shift around in his seat. The ALJ opined that Dr. Jilhewar's opinion suggested as much, but Dr. Jilhewar did not discuss the difference between sitting for four hours in a day versus six hours in a day anywhere in his testimony. Dr. Jilhewar did suggest that Dr. Ruiz's opinion did not present objective medical evidence of Plaintiff's back pain other than mild postural difficulties, but

the ALJ did not cite lack of evidence as support for preferring Dr. Jilhewar's opinion over Dr. Ruiz's. Rather, the ALJ simply described Dr. Jilhewar's opinion regarding Plaintiff's ability to sit as "more practical" because Dr. Jilhewar mentioned that Plaintiff should be permitted to shift in his seat. The overall context of the ALJ's statements lends support to Plaintiff's argument that the ALJ impermissibly "played doctor" when determining Plaintiff's RFC.

Similarly, neither Dr. Jilhewar nor the ALJ addressed either of Plaintiff's treating physicians' opinions or Plaintiff's own testimony that he needs to rest in a supine position at intervals during the day. The ALJ acknowledges that sitting without interruption can be tiring even for a person who does not have a back problem. However, the ALJ comes to the conclusion that shifting positions will provide Plaintiff adequate relief from pain without any explanation as to why he rejects Dr. Ruiz's opinion and Plaintiff's own testimony that he needs occasional rest breaks. Further, Dr. Jilhewar's testimony does not address Plaintiff's need for rest breaks at all. In this instance, it is illogical for the ALJ to wholly disregard the opinion of Plaintiff's treating physician on a point that the medical expert does not even address. The ALJ must at a minimum articulate his analysis of the evidence in order to allow this Court to follow his reasoning and to be assured that the ALJ considered the important evidence. *See Scott v. Barnhart*, 297 F.3d 589, 595 (7th Cir. 2002).

The Commissioner suggests that Dr. Jilhewar did not address Plaintiff's need to rest because Dr. Jilhewar found no objective evidence of lumbar fractures, compression or radiculopathy in the record. Such reasoning is merely speculation since the record does not clearly reveal Dr. Jilhewar's reason for failing to address Plaintiff's asserted need to rest. Moreover, the ALJ does not discuss lack of objective evidence of Plaintiff's pain as a reason for adopting Dr. Jilhewar's opinion or declining to address Plaintiff's alleged need for rest breaks.

Citing *Butera v. Apfel*, the Commissioner also argues that a treating physician's opinion is

not entitled to significant weight when the physician did not obtain evidence other than the patient's subjective complaints. 173 F.3d 1049, 1057 (7th Cir. 1999). The ALJ rejected Dr. Chube's opinion on such reasoning, but was unable to reject Dr. Ruiz's opinion on this basis because Dr. Ruiz's opinion was based on at least some objective medical evidence. Consequently, the ALJ understood that Dr. Ruiz's opinion was based on more than Plaintiff's subjective complaints.

In his reply brief, the Plaintiff suggests that the ALJ had a duty to recontact Dr. Chube as Plaintiff's treating physician pursuant to 20 C.F.R. § 404.1512(e) and SSR 96-5p. Section 404.1512(e)(1) of the regulation states that:

We will seek additional evidence or clarification from your medical source when the report from your medical source contains a conflict or ambiguity that must be resolved, the report does not contain all the necessary information, or does not appear to be based on medically acceptable clinical and laboratory diagnostic techniques.

Similarly, SSR 96-5p states that:

Because treating source evidence (including opinion evidence) is important, if the evidence does not support a treating source's opinion on any issue reserved to the Commissioner and the adjudicator cannot ascertain the basis of the opinion from the case record, the adjudicator must make "every reasonable effort" to recontact the source for clarification of the reasons for the opinion.

"An ALJ has a duty to solicit additional information to flesh out an opinion for which the medical support is not readily discernable." *Barnett v. Barnhart*, 381 F.3d 664, 669 (7<sup>th</sup> Cir. 2004).

The ALJ's reasons for rejecting Dr. Chube's opinion indicate that he thought Dr. Chube's opinion was not based on medically acceptable clinical and laboratory diagnostic techniques. In rejecting Dr. Chube's opinion, the ALJ emphasized that Dr. Chube had not submitted any documentation of any physical exam that he had performed on the Plaintiff or any radiological evidence to support his conclusions. The record indicates that Dr. Chube treated Plaintiff for several

years before Plaintiff's second hearing with the ALJ. Because Dr. Chube was Plaintiff's treating physician and the ALJ's reasons for rejecting Dr. Chube's opinion indicate that Dr. Chube had not based his decision on medically acceptable clinical and laboratory diagnostic techniques, the ALJ had a duty to recontact Dr. Chube pursuant to 20 C.F.R. § 404.1512(e) and SSR 96-5p.

*2. The ALJ properly considered Plaintiff's mental impairments when making an RFC determination.*

Plaintiff next argues that the ALJ made an incomplete and erroneous RFC assessment by failing to take Plaintiff's mental impairments into account when assessing Plaintiff's ability to work.

When an individual is not engaged in substantial gainful activity and the ALJ determines that the individual has a severe impairment that does not meet or equal the requirements of any impairment in the Listing of Impairments, the ALJ must continue with an assessment of the individual's residual functional capacity. SSR 96-8p. "RFC is an administrative assessment of the extent to which an individual's medically determinable impairment(s), including any related symptoms, such as pain, may cause physical or mental limitations or restrictions that may affect his or her capacity to do work- related physical and mental activities." *Id.* An RFC represents the most that an individual can do in spite of his or her restrictions. *Id.* The ALJ's RFC assessment must be based on all of the relevant evidence in the case record and must consider the limitations and restrictions imposed by all of the claimant's impairments, even when the alleged impairments are not severe. *Id.* Even if the ALJ has concluded that certain of Plaintiff's impairments are not severe, those impairments combined with the impairments that the ALJ has found to be severe may narrow the range of work that the claimant is able to perform. *Id.* In order for an individual to perform the

full range of work at a given exertional level, the individual must be able to perform substantially all of the functions required in work at that exertional level. *Id.* A function-by-function assessment of the Plaintiff's RFC could be critical to the outcome of a case in that such assessment enables the ALJ to determine whether the individual is capable of the full range of work at an exertional level. *Id.*

When a Plaintiff presents evidence of a mental impairment, the ALJ is required to follow a special technique and document the application of the technique in his or her decision. *See* 20 C.F.R. §§ 404.1520(a) and (e). The regulations require the SSA to: (1) evaluate the claimant's symptoms and any relevant laboratory findings; (2) rate the degree of functional limitation in the areas of daily living, social functioning, concentration, persistence or pace, and episodes of decompensation in terms of "none, mild, moderate, marked and extreme"; and (3) document such application clearly in the ALJ's decision. 20 C.F.R. §§ 404.1520(a), (b) and (e).

The Plaintiff argues that the ALJ committed harmful error by rejecting evidence in the record showing that Plaintiff had a severe mental impairment, by failing to perform a mental RFC evaluation, by failing to elicit a sufficient opinion from the medical expert regarding Plaintiff's mental RFC, and by failing to obtain a medical source statement from the consultative examiner.

The ALJ's opinion indicates that, in determining the severity of Plaintiff's mental impairment, he considered the 2000 opinion of DDS physician Dr. Odeluga, the 2000 opinion of a DDS consultative examiner Dr. Gange, the 2002 opinion of consultative examiner Dr. Kalyani Gopal, the 2005 opinion of consultative examiner Dr. Shashi Anand, and the 2005 assessment by a mental health professional at the Tri-City Health Clinic. When he reviewed the evidence, the ALJ noted that Dr. Odeluga diagnosed Plaintiff in accordance with Plaintiff's own report and without any indication that Plaintiff exhibited any symptoms of anxiety. The ALJ also mentions that Dr. Gange

found Plaintiff's mental condition not severe when he reviewed Dr. Odeluga's report. Contrary to Plaintiff's assertions that the ALJ failed to obtain MRFC forms from the consultative examiners, the Agency twice referred Plaintiff to consultative examiners and in both instances, the consultative examiners (Drs. Gopal and Anand) completed and submitted MRFC forms with their opinions indicating that Plaintiff's condition did not affect his ability to work.

All of the above physicians indicated that Plaintiff's condition was "mild" to "none" in each of the four applicable categories set out in regulation 20 C.F.R. §§ 404.1520a. None of the physicians found any indication that Plaintiff's mental impairments affected his ability to work. The GAF score Tri-City Health Center assigned to Plaintiff is lower than those the consultative examiners assigned to Plaintiff and indicates that the Tri-City Health counselor thought that Plaintiff's mental impairments were more severe. However, the GAF score from Tri-City Health Center directly conflicts with the findings of all of the other mental health professionals in the record.

Nevertheless, the ALJ's opinion indicates that he considered Plaintiff's testimony and all of the records of Plaintiff's six weeks of treatment at the Tri-City Health Center in conjunction with the other medical opinions in determining that the Plaintiff's mental impairments did not affect his ability to work. Although the assessment from the mental health professionals at Tri-City Health Center did not include an MRFC form, the Plaintiff did not raise this point in his brief and it is therefore waived. Accordingly, the Court finds that the ALJ's opinion that the Plaintiff's mental impairments are not severe was supported by substantial evidence.

Moreover, the ALJ followed the applicable regulations by considering each medical opinion and then indicating specifically that he had determined that Plaintiff's anxiety disorder and possible adjustment disorder caused no more than mild restrictions on Plaintiff's daily living, social

functioning, ability to maintain concentration, persistence and pace, and that Plaintiff had not had any episodes of decompensation.

Plaintiff argues that Dr. Jilhewar was unable to adequately testify in regard to the effects of Plaintiff's mental impairments on his RFC and that the ALJ relied heavily on Dr. Jilhewar's testimony in determining Plaintiff's RFC. However, the ALJ's opinion does not indicate that he relied on Dr. Jilhewar's testimony for anything more than the resolution of the conflicting evidence with regard to Plaintiff's physical abilities.

Finally, the Plaintiff invites the Court to consider the possibility that Plaintiff may have developed post-traumatic stress disorder. The Court declines to consider such a possibility because the Court's review of the ALJ's opinion is limited to determining whether the ALJ's opinion is supported by substantial evidence or contains errors of law. *See Lopez v. Barnhart*, 336 F.3d 535, 539 (7th Cir. 2003). This Court will not re-weigh evidence or consider evidence outside the record in the process of reviewing the ALJ's opinion. *See Boiles v. Barnhart*, 395 F.3d 421, 425 (7th Cir. 2005).

*3. The ALJ adequately considered the effect of Plaintiff's obesity in determining his RFC.*

The Plaintiff also argues out that the ALJ's RFC assessment failed to consider the effect of Plaintiff's obesity on his ability to work. The ALJ's RFC assessment must consider the limitations and restrictions imposed by all of the claimant's impairments, even when the alleged impairments are not severe. SSR 96-8p. Obesity must be considered for its incremental effects, if any, on the claimant's impairments. *See Gentle v. Barnhart*, 430 F.3d 865, 868 (7<sup>th</sup> Cir. 2005).

The record itself contains very few references to Plaintiff's obesity and Plaintiff does not

allege that his obesity in particular affected his ability to work. As the Defendant points out, medical expert Dr. Jilhewar specifically discussed Plaintiff's obesity when he provided his opinion on the contours of Plaintiff's RFC. In fact, Dr. Jilhewar's testimony includes a more detailed and thorough discussion of Plaintiff's obesity than any other medical opinion in the record. The ALJ subsequently adopted Dr. Jilhewar's opinion regarding the Plaintiff's RFC.

Although the ALJ did not specifically discuss the Plaintiff's obesity in his opinion, the Defendant argues that the ALJ acted consistently with *Sienkiewicz v. Barnhart*, 409 F.3d 798, 803-04 (7<sup>th</sup> Cir. 2005), because his RFC finding was consistent with the opinion of a physician who gave thorough consideration to Plaintiff's obesity. However, unlike the ALJ in *Sienkiewicz*, ALJ Asbille did not make specific findings concerning Plaintiff's obesity in his opinion.

The ALJ is not required to address "every piece of evidence or testimony in the record, [but] the ALJ's analysis must provide some glimpse into the reasoning behind [the] decision to deny benefits." *Zurawski v. Halter*, 245 F.3d 881, 888 (7<sup>th</sup> Cir. 2001). The ALJ's logic would have been easier for this Court to follow had the ALJ specifically addressed Plaintiff's obesity. Nevertheless, the Court finds that the ALJ's adoption of Dr. Jilhewar's opinion of Plaintiff's RFC demonstrates sufficient consideration of Plaintiff's obesity.

The Plaintiff also cites *Barrett v. Barnhart*, 355 F.3d 1065 (7<sup>th</sup> Cir. 2004) to support the proposition that the ALJ committed harmful error by failing to consider Plaintiff's obesity. However, the facts of *Barrett* involved a severely obese individual who sought disability benefits specifically on the basis of her severe morbid obesity and osteoarthritis. *Id.* at 1066. Unlike ALJ Asbille in the present case, the ALJ in *Barrett* found Barrett's obesity to be severe, but did not consider its effects on her other impairments when determining her RFC, either directly or through

the medical evidence. *Id.* at 1068. Consequently, the reviewing Court was unable to trace the ALJ's logic and was forced to remand the case. *Id.* at 1068-69. Such is not the case here, and this Court finds that the ALJ sufficiently considered the effects of Plaintiff's obesity on his other impairments.

#### *4. The ALJ Posed Incomplete Hypotheticals to the VE.*

Where an ALJ relies on testimony from a vocational expert ("VE") to make a disability determination, the ALJ must form his questions to include all relevant limitations of record from which the claimant suffers. *Patty v. Barnhart*, 189 Fed. Appx. 517, 521 (7<sup>th</sup> Cir. 2006); *Hofslien v. Barnhart*, 172 Fed. Appx 116, 120 (7<sup>th</sup> Cir. 2006). When the ALJ poses hypotheticals to the VE, the hypotheticals must include all limitations supported by evidence in the record so that the VE will not refer Plaintiff to jobs that the Plaintiff cannot perform because the VE was unaware of all of the Plaintiff's limitations. *See Patty v. Barnhart*, 189 Fed. Appx. at 521; *Steele v. Barnhart*, 290 F.3d 936, 942 (7<sup>th</sup> Cir. 2002).

In this case, the ALJ relied on the VE's testimony to make his determination at step five of the disability analysis; however, the hypothetical the ALJ posed to the VE did not include Plaintiff's anxiety and depression, both of which are extensively documented throughout the record. Because the ALJ failed to incorporate all of Plaintiff's impairments in his hypothetical to the VE, the hypothetical was flawed and cannot support a denial of benefits. *See* 20 C.F.R. § 404.920. When the ALJ poses hypotheticals to the VE, those hypotheticals must include all limitations supported by evidence in the record so that the VE will not refer Plaintiff to jobs that the Plaintiff cannot perform. *See Patty v. Barnhart*, 189 Fed. Appx. at 521; *Steele v. Barnhart*, 290 F.3d at 942. In this instance, the ALJ failed to include reference to Plaintiff's anxiety and depression, both of which are

amply documented throughout the record. Consequently, the ALJ's erroneous hypotheticals to the VE constitute legal error and require remand.

### **B. The ALJ's Credibility Determination**

The Social Security regulations provide that, in making a disability determination, the Commissioner will consider a claimant's statements about his symptoms, including pain, and how they affect the claimant's daily life and ability to work. *See* 20 C.F.R. 404.1529(a) & 416.929(a). The Social Security regulations establish a two-part test for determining whether complaints of pain contribute to a finding of disability: (1) the claimant must provide objective medical evidence of a medically determinable impairment or combination of impairments that could reasonably be expected to produce the symptoms alleged; and (2) once an ALJ has found an impairment that reasonably could cause the symptoms alleged, the ALJ must consider the intensity and persistence of the symptoms. *See* 20 C.F.R. 404.1529(a), (c) & 416.929(a), (c); *see also Johnson v. Barnhart*, 449 F.3d 804, 806 (7th Cir. 2006).

The ALJ must weigh the claimant's subjective complaints and the relevant objective medical evidence, as well as any other evidence of the following factors:

- (1) The individual's daily activities;
- (2) Location, duration, frequency, and intensity of pain or other symptoms;
- (3) Precipitating and aggravating factors;
- (4) Type, dosage, effectiveness, and side effects of any medication;
- (5) Treatment, other than medication, for relief of pain or other symptoms;

(6) Other measures taken to relieve pain or other symptoms; and

(7) Other factors concerning functional limitations due to pain or other symptoms.

20 C.F.R. 404.1529 (c)(3) & 416.929(c)(3).

In making the credibility determination, Social Security Ruling 96-7p dictates that the ALJ "must consider the entire case record, including the objective medical evidence, the individual's own statements about symptoms, statements and other information provided by treating or examining physicians or psychologists and other persons about the symptoms and how they affect the individual, and any other relevant evidence in the case record." SSR 96-7p at \*1. The Ruling provides that the "determination or decision must contain specific reasons for the finding on credibility, supported by the evidence in the case record, and must be sufficiently specific to make clear to the individual and to any subsequent reviewers the weight the adjudicator gave to the individual's statements and the reasons for that weight." SSR 96-7p; *see also Steele v. Barnhart*, 290 F.3d at 942. It is not sufficient for the ALJ to articulate a credibility finding with a conclusory statement that "the individual's allegations have been considered" or that "the allegations are (or are not) credible." SSR 96-7p.

An ALJ is not required to give full credit to every statement of pain or to find a disability every time a claimant states that he or she is unable to work. *Rucker v. Chater*, 92 F.3d 492, 496 (7th Cir. 1996). However, Ruling 96-7p provides that a claimant's statements regarding symptoms or the effect of symptoms on her ability to work "may not be disregarded solely because they are not substantiated by objective evidence." SSR 96-7p at \*6; *Johnson v. Barnhart*, 449 F.3d 804, 806 (7th Cir. 2006) (explaining that an ALJ may not discredit a claimant's allegations of pain merely because those allegations exceed the objective medical evidence).

"[T]he adjudicator may also consider his or her own recorded observations of the individual as part of the overall evaluation of the credibility of the individual's statements." SSR 96-7p. As the Seventh Circuit has stated, "[B]ecause hearing officers are in the best position to see and hear the witnesses and assess their forthrightness, we afford their credibility determinations special deference." *Powers v. Apfel*, 207 F.3d 431, 435 (7th Cir. 2000) (internal quotations and citations omitted). *See also Sims v. Barnhart*, 442 f.3d 536, 538 (7<sup>th</sup> Cir. 2006) ("Credibility determinations can rarely be disturbed by a reviewing court, lacking as it does the opportunity to observe the claimant testifying"). Generally, an ALJ's credibility determination will not be overturned unless it was "patently wrong." *Prochaska v. Barnhart*, 454 F.3d 731, 738 (7<sup>th</sup> Cir. 2006). However, when "credibility determinations rest on objective factors or fundamental implausibilities rather than subjective considerations, appellate courts have greater freedom to review the ALJ's decision." *Palmer v. Barnhart*, 40 F. Appx. 278, 283 (7th Cir. 2002). Finally, even if there is sufficient evidence in the record to support the ALJ's credibility determination, the ALJ must present "specific reasons" for his or her finding, and not simply recite the factors listed in the regulations. SSR 96-7p.

The Plaintiff argues that the ALJ did not provide sufficient evidence to support his adverse credibility determination. Alternatively, the Plaintiff argues that GAF scores should be given less weight than individual doctors' diagnoses because GAF scores reflect a person's mind at a single point in time. The Plaintiff criticizes the ALJ for focusing only on the GAF scores that are less favorable to Plaintiff's claim and suggests that the ALJ should have averaged his GAF scores.

The ALJ concluded that the Plaintiff's testimony regarding the impact of his mental impairments on his ability to work was less than fully credible because his reports of his mental health problems were significantly worse than those which the mental health professionals observed in their evaluations. Because the ALJ's reason for rejecting Plaintiff's testimony about his mental

health problems rested on an objective factor and/or fundamental implausibility, rather than subjective considerations, this Court has greater freedom to review the ALJ's decision. *Palmer v. Barnhart*, 40 F. Appx. 278, 283 (7th Cir. 2002). However, the Court finds the Plaintiff's arguments asserting error in the ALJ's credibility determination to be unconvincing.

The record indicates that in interviewing the Plaintiff, the ALJ considered all of the factors required by the regulations. The ALJ asked the Plaintiff what he did each day and also about the specifics of his mental disorders. The ALJ asked the Plaintiff about situations that triggered his anxiety, his medications, and how he felt the anxiety limited his ability to function. Contrary to Plaintiff's assertion that the ALJ dismissed Plaintiff's allegations of his mental health problems without consideration, the ALJ's opinion indicates that he extensively considered the opinions of the mental health professionals who evaluated Plaintiff over the relevant period. The ALJ did not reject the Plaintiff's subjective complaints as simply unsupported by objective evidence, but rather, only as being in *excess* of the evidence gleaned from the evaluations of the doctors who had reviewed the Plaintiff's mental status. Moreover, consistent with the requirements of SSR 96-7p, the ALJ was specific in his reason for rejecting Plaintiff's testimony.

Although the ALJ mentions the GAF score from each mental health professional's evaluation of the Plaintiff, nothing in the ALJ's opinion suggests that his determination of Plaintiff's credibility is in any way based solely or even mostly on Plaintiff's various GAF scores or that the ALJ failed to consider each of the doctors' individual diagnoses. Moreover, the Plaintiff cites no legal basis which would require the ALJ to average GAF scores.

In light of the objective medical evidence of record, the ALJ was not unreasonable in finding Plaintiff's testimony regarding his mental status not totally credible. The Court finds that the Plaintiff has not demonstrated that the ALJ's credibility determination was "patently wrong" and that

the ALJ rationally articulated the grounds for his decision.

### CONCLUSION

The Court finds that the ALJ had a duty to recontact Plaintiff's treating physician Dr. Chube; that the ALJ committed harmful error by performing an erroneous RFC by failing to adequately articulate his reasons for rejecting treating physician Dr. Ruiz's opinion and failing to address Plaintiff's asserted need for rest breaks; and that the ALJ erred when he failed to incorporate all of Plaintiff's impairments into the hypotheticals posed to the VE. Therefore, to that extent, the Court **GRANTS** the Plaintiff's Motion for Summary Judgment [DE 17]. The decision of the ALJ is **REVERSED** and **REMANDED** under sentence four of 42 U.S.C. § 405(g) for further proceedings consistent with this Order.

SO ORDERED this 29<sup>th</sup> day of March, 2007.

s/ Paul R. Cherry

MAGISTRATE JUDGE PAUL R. CHERRY

UNITED STATES DISTRICT COURT

cc: All counsel of record