IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

MARY KAY JONES,

Plaintiff,

v.

LARRY G. MASSANARI,
Acting Commissioner of Social Security,

Defendant.

REPORT AND
RECOMMENDATION

01-C-0024-C

REPORT

This is an appeal of a final decision of the Commissioner of Social Security brought pursuant to 42 U.S.C. § 405(g). Plaintiff Mary Kay Jones contends the Commissioner erred in concluding that she did not meet the statutory criteria for a finding of disability and entitlement to disability insurance benefits before March 31, 1996, the date she was last insured under Title II of the Social Security Act, 42 U.S.C. §§ 401-433. Plaintiff contends that the Administrative Law Judge who denied her claim at the administrative hearing stage committed the following errors: 1) failed properly to inform plaintiff of her right to representation and failed to develop the record fully and fairly; 2) failed to evaluate properly plaintiff's subjective complaints in relation to her fibromyalgia; 3) failed to evaluate properly plaintiff's mental condition; 4) failed to follow the regulations with respect to determining plaintiff's onset date; and 5) failed to account properly for all of plaintiff's non-exertional

limitations in his residual functional capacity assessment. Plaintiff asks this court to reverse the decision of the Commissioner and to award her benefits, or alternatively to remand the case to the Commissioner for further proceedings.

Having carefully reviewed the administrative record and the ALJ's written decision, I conclude that this court should affirm the decision of the Commissioner. Although it appears undisputed that plaintiff is disabled *now* from one or more impairments, substantial evidence in the record supports the ALJ's conclusion that plaintiff was able to perform a substantial number of jobs in the regional economy at all times on or before March 31, 1996 despite her various impairments. As discussed below, the ALJ properly applied the regulations, considered all the relevant evidence, explained how he was weighing the evidence and drew conclusions that are supported by adequate evidence in the record.

The following facts are drawn from the administrative record:

FACTS

I. Procedural History

Plaintiff filed an application for Social Security Disability Benefits on June 4, 1996, alleging that she had been disabled since August 20, 1993, as a result of hearing problems, carpal tunnel syndrome, chronic joint pain and mental problems.[1] The application was

[1] This was plaintiff's second application for disability insurance benefits. Plaintiff filed her first application on October 12, 1994, but abandoned it after it was denied at the reconsideration stage. At the administrative hearing on the instant application, plaintiff argued that her first application should be reopened if the ALJ found in her favor.

denied initially and upon reconsideration. Pursuant to plaintiff's request, an administrative hearing was held on March 20, 1998. Plaintiff appeared at the hearing with a non-attorney representative, Bonnie Niemi, a disability benefits consultant from Hauck Disability Consulting Services, Inc. Plaintiff, her husband, a medical expert and a vocational expert testified at the hearing.

In a decision dated June 25, 1998, the ALJ concluded that plaintiff was not disabled for the purposes of disability insurance benefits on or before her date last insured, which was March 31, 1996. Plaintiff filed a request for review with the Appeals Council and retained an attorney. Plaintiff submitted additional evidence but the Appeals Council added only a portion of it into the administrative record, finding that most of the additional medical records were not material because they related either to the time period before plaintiff's alleged onset date or after her date last insured. The Appeals Council denied review on November 9, 2000, making the decision of the ALJ the final decision of the Commissioner.

II. Hearing Testimony

Plaintiff was born on March 23, 1960, making her 38 years old at the time of the administrative hearing. She has past work experience as a secretary for a lumber company. Plaintiff stopped working in 1991 to care for her husband and son who both had pneumonia. She lives in a house with her husband and two sons, who were aged seven and four at the time of the hearing.

Plaintiff has been plagued by medical problems for most of her life. Her medical history indicates that she suffers from degenerative changes in the spine and knee, chronic fatigue, diarrhea, morbid obesity, a non-functioning kidney, carpal tunnel syndrome, hypertension, hearing loss, depression, a somatoform pain disorder and fibromyalgia. At the administrative hearing, plaintiff testified that as a result of her impairments, she experiences daily burning pain, numbness in her hands, fatigue and difficulty sleeping, concentrating and remembering things. She testified that she relies on her husband to do most of the housework and shopping and to help care for their children. Plaintiff testified that she occasionally has good days on which she can help fold laundry and prepare some meals but otherwise she is pretty much sedentary during the day. Her husband corroborated her testimony, indicating that plaintiff's condition had worsened progressively since 1991. Comparing plaintiff's present condition to her condition in 1996, plaintiff's husband indicated that it was much worse at the time of the hearing than it had been in 1996.

III. Medical Evidence

The voluminous administrative record contains records of plaintiff's treatment and evaluation for a variety of medical problems from August 1991 through January 1998. Dr. James Hammarsten, a medical expert called by the ALJ to testify at the hearing, testified that the records showed that plaintiff had the following impairments: hearing loss; irritable bowel syndrome manifested by diarrhea; obesity; hypertension; x-rays of the spine showing

irregularities consistent with vertebral epiphysitis, hypertrophic changes throughout the spine, degenerative changes in the thoracic spine and slight narrowing of the L3 interspace; mild carpal tunnel syndrome on the right; fibromyalgia as diagnosed by the Mayo Clinic in 1994; mild degenerative changes in the left knee; and somatoform disorder and depression as shown by the results of an MMPI administered by Dr. Anthony Malozzi on January 8, 1998.

Dr. Hammarsten concluded that none of plaintiff's impairments were severe enough on March 31, 1996 to meet the criteria for a listed impairment. Dr. Hammarsten testified that although testing performed on November 14, 1996, showed that plaintiff had hearing loss severe enough to meet the listings, earlier testing performed in June 1994 indicated that plaintiff's hearing loss had not met the listings as of that time. As for plaintiff's mental impairments, Dr. Hammarsten testified that "it would be very difficult to say from the records" that any of plaintiff's mental impairments were severe enough to meet the listings as of March 31, 1996. AR 802. Dr. Hammarsten opined that none of plaintiff's other impairments was severe enough to satisfy the listings.

Dr. Hammarsten testified that although plaintiff's medical records showed treatment for a variety of medical problems, the principal impairment documented in the records for the time period between August 1993 and March 31, 1996 was fibromyalgia. In spite of plaintiff's various physical and mental impairments, Dr. Hammarsten opined that as of March 31, 1996 plaintiff could perform routine, repetitive light work with no kneeling, no

crawling, very little crouching or stooping, no use of ladders, no use of stairs, no lifting from the floor, no work requiring high concentration and no repetitive keyboard work.

IV. Vocational Evidence

Edward Utities testified as a vocational expert at the hearing. The ALJ asked Utities to assume a hypothetical claimant of plaintiff's age, education and work experience with the medical impairments as testified to by Dr. Hammarsten and who was limited to simple, unskilled light work requiring no more than three or four-step instructions, with no kneeling, crawling, use of ladders, climbing of stairs, no more than occasional stooping or crouching, no lifting from the floor, no repetitive right-hand work and no work around unprotected, dangerous machinery. Utities testified that such an individual would be unable to perform plaintiff's past work as a secretary because such work required more than three to four steps of instruction and would likely require repetitive keyboarding. However, he testified that such an individual could perform bench wrapping, packaging or assembly jobs and that such jobs existed in significant numbers in the regional economy. He testified that if the exertional level was changed from light to sedentary, it would eliminate the wrapping/packing jobs but not the assembly jobs. He further testified that although the assembly jobs would have a minimal production requirement, they were not high production positions such as those on an assembly line. Finally, Utities testified that these same jobs would be available

even if the hypothetical claimant had the additional restriction that she have only brief, superficial contacts with the public.

In response to questioning by claimant's representative, Utities testified that no jobs would be available to an individual who was likely to miss work one or two times a week or who would have to leave the work station for prolonged periods aside from normal lunch and bathroom breaks.

V. The ALJ's Decision

Relying on Dr. Hammarsten's opinion, the ALJ concluded that the medical evidence showed that plaintiff suffered from many physical impairments–hypertension, hearing loss, irritable bowel, obesity, degenerative changes of the thoracic and lumbar spine, mild carpal tunnel syndrome on the right, fibromyalgia and degenerative changes in the left knee–but that none of these impairments were accompanied by the clinical findings necessary to support a finding that on or before March 31, 1996 they singly or in combination met or equaled any impairment listed in Appendix 1, Subpart P, Regulations No. 4 ("the listings").

The ALJ then evaluated plaintiff's mental impairments. He observed that with the exception of records from one visit in August 1991, the record contained no evidence to support plaintiff's contention that she had received mental health treatment from Dr. Anthony Mullozzi from August 1991 through March 31, 1996. Acknowledging his duty to develop the record fully and fairly, the ALJ found

> no indication that the claimant's representative requested and/or submitted the August 1991 through March 31, 1996 records from Dr. Mullozzi, requested the undersigned to obtain these records, or requested that the medical record be left open for submission of these records. Thus, the undersigned is unable to place full credibility on the assertions with respect to a treatment history extending from August 1991 through claimant's date last insured. If the treatment relationship and records exist, the undersigned concludes that the records are of only minor importance or do not bolster the claimant's claim for disability based on the claimant's representative's failure to submit any treatment records from Dr. Mullozzi for the period, August 1991 through claimant's date last insured.

AR 18.

The ALJ concluded that plaintiff suffered from an affective disorder and a somatoform disorder that resulted in functional limitations, but found that the lack of contemporaneous mental health records was a reason to discount the credibility of plaintiff's complaints regarding her mental limitations on or before her date last insured. Utilizing the categories from the Psychiatric Review Technique Form, the ALJ found that on or before March 31, 1996, the degree of plaintiff's functional limitations was not severe enough to meet the listings. Specifically, the ALJ found that plaintiff's mental impairments resulted in moderate restriction of activities of daily living; slight to moderate difficulties in maintaining social functioning; often deficiencies in concentration, persistence and pace; and no episodes of deterioration or decompensation in work or work-like settings. To accommodate for these mental limitations, the ALJ found that plaintiff could perform simple, unskilled work with three or four step instructions requiring only superficial contact with the public and no high production goals or quotas.

In reaching the conclusion that plaintiff's mental impairments were not disabling on or before March 31, 1996, the ALJ cited the lack of evidence that plaintiff received mental health treatment before her eligibility for disability insurance benefits expired and her failure to allege depression as a disabling impairment when she completed benefit application forms in 1995. In addition, he relied heavily on a consultative mental status examination performed by psychologist Marcus Desmonde on May 12, 1995. From his examination of plaintiff, Desmonde found insufficient evidence to support either a clinical mental disorder or personality disorder, but found that plaintiff had muscle pain of undetermined etiology and a mood disorder due to pain and side effects of anti-hypertension medication. He found that plaintiff had significant psychosocial stressors but gave her a score of 85-95 for the past year on the Global Assessment of Functioning scale, indicating that plaintiff had minimal symptoms and no more than slight impairment in social or occupational functioning. *See Diagnostic and Statistical Manual of Mental Disorders* (4th ed. 2000) (text revision), at 34. Desmonde concluded that plaintiff appeared capable of concentrating on and understanding instructions, carrying out tasks with reasonable persistence and pace, responding appropriately to co-workers and supervisors, and tolerating stress in the work place.

The ALJ then evaluated the credibility of plaintiff's subjective complaints by considering each of the factors described in 20 C.F.R. § 404.1529. First, the ALJ reviewed the medical evidence relating to each of plaintiff's impairments and concluded that, overall, it was not consistent with plaintiff's complaints of disabling pain and functional limitations.

The ALJ found that although plaintiff had been diagnosed with fibromyalgia, she reported to her doctor in June 1995 that she experienced flare-ups of her fibromyalgia every other month and that it was usually controlled well by Ibuprofen. He also noted that plaintiff declined to participate in a fibromyalgia program that her doctor recommended. Although the ALJ acknowledged that plaintiff indicated that her insurance would not cover the cost of the program, he found that explanation uncompelling, noting that plaintiff's husband received disability payments exceeding $1,600 per month and that there was no evidence that plaintiff attempted to seek out low-cost treatment alternatives.

The ALJ found that plaintiff suffered from hearing loss, but that her responses at the hearing and other evidence in the record indicated that she was able to hear adequately with hearing aids. As for the degenerative changes in her back and left knee, the ALJ found no evidence that plaintiff had followed through with physical therapy when it was recommended. Further, he noted that plaintiff did not use a cane or brace and her doctors had not recommended surgery for her conditions. Likewise, with respect to plaintiff's carpal tunnel syndrome on the right, he noted that there was no evidence that plaintiff had been instructed to wear a brace or splint or that surgery had been recommended.

The ALJ discussed in detail the evidence relating to the other factors described in 20 C.F.R. § 404.1590 including plaintiff's course of medical treatment, her use of medication, her daily activities, the statements and testimony of plaintiff's husband, the statements of plaintiff's neighbor and pastor, and plaintiff's work history. The ALJ discounted some of this

evidence because it related to plaintiff's condition after March 1996. The ALJ acknowledged that the evidence was consistent overall with her diagnosed conditions, but concluded that it was not consistent with her claim that she could perform no work on or before March 31, 1996. Relying heavily on the opinion of Dr. Hammarsten, the ALJ concluded that plaintiff had the residual functional capacity to perform a limited range of unskilled, sedentary work. On the basis of the vocational expert's testimony, the ALJ found that although plaintiff's limited residual functional capacity precluded her from performing her past work, there were approximately 6,000 assembly jobs in the regional economy that she could perform despite her limitations.

The ALJ made the following specific findings:

1. The claimant met the insured status requirement on August 20, 1993, and continued to meet that requirement through March 31, 1996.

2. The claimant has not engaged in substantial gainful activity at any time relevant to this adjudication.

3. The medical evidence establishes that the claimant is severely impaired by hearing loss, irritable bowel, obesity, degenerative changes in the thoracic and lumbar spine, carpal tunnel syndrome, mild on the right, fibromyalgia, hypertension, and degenerative changes in the left knee, but these impairments are not accompanied by the clinical findings necessary for a conclusion that they individually or in combination meet or equal any listing in the Listing of Impairments in Appendix 1, Subpart P, Regulations No. 4.

4. The claimant's allegations of disabling pain and mental and functional limitations at all times on or prior to her date last insured are credible to the extent that the claimant's impairments could reasonably cause some discomfort and limitation of function. However, the allegations made by the claimant and her husband and third-party statements in the record of overall disability are not credible in light of the overall hearing record, objective medical evidence, claimant's own testimony,

claimant's husband's testimony, third-party statements and observations in the record, and significant inconsistencies in the record as a whole.

5. At all times relevant to this adjudication on or prior to claimant's date last insured, the claimant retained the residual functional capacity for sedentary exertional level work with no kneeling, crawling, use of ladders, or climbing stairs, very little or occasional stooping and crouching, no lifting from the floor in a standing position, simple, unskilled three-to-four steps instructions with brief and superficial contact with the public, no high production goals or quotas, no repetitive right hand work a major part of the day such as use of keyboards, and no work at unprotected, dangerous machinery where the individual may not be able to hear.

6. The claimant is unable to perform her past relevant work, because this work is beyond her residual functional capacity as she performed it or as it is generally performed in that national economy.

7. At all times relevant to this adjudication, the claimant is a younger individual with a high school education and cosmetology training, and past relevant work as a secretary with no work skills transferable to jobs within her residual functional capacity based on her mental impairments and/or degree of pain.

8. When considering the claimant's age, education, and work experience in conjunction with her maximum sustained work capability and the credible and persuasive neutral vocational expert testimony, there are a significant number of jobs existing in the regional or national economy that the claimant can perform such as assembly.

9. The claimant has not been under a disability as defined in the Social Security Act at any time since August 20, 1993 through March 31, 1996, the claimant's date last insured for entitlement to Title II benefits.

Additional facts will be discussed in the analysis section that follows.

ANALYSIS

I. Legal and Statutory Framework

Under the Social Security Act, a disability is the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months." 42 U.S.C. § 1382c(a)(3)(A). A physical or mental impairment is "an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques." 42 U.S.C. § 1382c(a)(3)(C).

The Commissioner has promulgated regulations setting forth the following five-step sequential inquiry to determine whether a claimant is disabled:

(1) Is the claimant currently employed?

(2) Does the claimant have a severe impairment?

(3) Does the claimant's impairment meet or equal one of the impairments listed by the SSA?

(4) Can the claimant perform his or her past work? and

(5) Is the claimant is capable of performing work in the national economy?

See 20 C.F.R. § 416.920.

In seeking benefits the initial burden is on the claimant to prove that a severe impairment prevents her from performing past relevant work. If she can show this, the

burden shifts to the Commissioner to show that plaintiff is able to perform other work in the national economy despite the severe impairment. *See Stevenson v. Chater*, 105 F.3d 1151, 1154 (7th Cir. 1997); *Brewer v. Chater*, 103 F.3d 1384, 1391 (7th Cir. 1997).

Under 42 U.S.C. § 405(g), the Commissioner's findings are conclusive if they are supported by "substantial evidence." *See Stevenson*, 105 F.3d at 1153; *Brewer*, 103 F.3d at 1390. "Substantial evidence is more than a mere scintilla. It is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Stevenson*, 105 F.3d at 1153 (quoting *Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938), as quoted in *Richardson v. Perales*, 402 U.S. 389, 401 (1971)) (other citations omitted). A standard this low could allow for different supportable conclusions in a given claimant's case. That being so, this court cannot in its review reconsider facts, reweigh the evidence, decide questions of credibility, or otherwise substitute its own judgment for that of the ALJ regarding what the outcome should be. *See Brewer*, 103 F.3d at 1390 (citations omitted); *Kapusta v. Sullivan*, 900 F.2d 94, 96 (7th Cir. 1990).

Although the ALJ's reasonable resolution of evidentiary inconsistencies is not subject to review, *see Brewer*, 103 F.3d at 1390, and the ALJ's written opinion need not evaluate every piece of testimony and evidence submitted, the ALJ "must at least minimally discuss a claimant's evidence that contradicts the Commissioner's position." *Godbey v. Apfel*, 238 F.3d 803, 808 (7th Cir. 2001). The ALJ's opinion must adequately articulate how the evidence was weighed so that this court may trace the path of his or her reasoning. *Id.* For

example, ignoring an entire line of evidence would fail this standard. *Diaz v. Chater*, 55 F.3d 300, 307 (7th Cir. 1995). However, as with any fact finder, the ALJ is entitled to choose between competing opinions. *Luna v. Shalala*, 22 F.3d 687, 690 (7th Cir. 1994). Most importantly, "the ALJ must build an accurate and logical bridge from the evidence to his conclusion." *Clifford v. Apfel*, 227 F.3d 863, 872 (7th Cir. 2000).

II. Failure to Develop Record

Plaintiff contends the ALJ committed legal error by failing to inform plaintiff that she had the right to an attorney and by failing to develop the record fully and fairly. She argues that neither her non-attorney representative nor the ALJ adequately protected her right to a fair hearing because they failed to obtain or consider all the relevant medical evidence and failed to properly question the vocational expert.

A claimant has a statutory right to counsel at a disability hearing. 42 U.S.C. § 406; 20 C.F.R. 404.1700. In *Thompson v. Sullivan*, 933 F.2d 581 (7th Cir. 1991), the Court of Appeals for the Seventh Circuit held that to ensure that a claimant has waived this statutory right validly, the ALJ must explain to the pro se claimant (1) the manner in which an attorney can aid in the proceedings, (2) the possibility of free counsel or a contingency arrangement, and (3) the limitation on attorney fees to 25 percent of past due benefits and required court approval of the fees. *Id.* at 584. Moreover, although the Act permits a claimant to choose an attorney or a non-attorney representative, 42 U.S.C. § 406, the

non-attorney representative must be "capable of giving valuable help . . . in connection with [the] claim." 20 C.F.R. §§ 404.1705(b)(2) and 416.1505(b)(2).

When the ALJ does not obtain a valid waiver, the burden is on the Commissioner to show that the ALJ fully and fairly developed the record. *Binion v. Shalala*, 13 F.3d 243, 245 (7th Cir. 1994). This duty requires that the ALJ "scrupulously and conscientiously probe into, inquire of, and explore for all the relevant facts." *Thompson*, 933 F.2d at 585. If the Commissioner establishes that the record was developed fully and fairly, the plaintiff may rebut this showing by demonstrating prejudice or an evidentiary gap. *Binion*, 13 F.3d at 245.

The Commissioner does not attempt to defend the adequacy of the waiver of counsel but contends that plaintiff was not prejudiced because the ALJ fully and fairly developed the record. I agree. Although plaintiff endeavors mightily to show that she was denied a fair and full hearing, the transcript shows otherwise. The ALJ elicited detailed testimony from plaintiff at the hearing regarding her pain, physical and mental ability to perform various activities, daily activities, medications and medical treatment. He also asked plaintiff's husband numerous questions about plaintiff's health and limitations before the date on which she was last insured for disability benefits. Plaintiff's representative followed up with several questions of both plaintiff had her husband. The hearing was comprehensive, lasting two hours. The record contained 59 exhibits totaling nearly 600 pages. In addition, the ALJ reopened the record to admit a post-hearing memorandum and article about fibromyalgia that was submitted by plaintiff's representative.

Plaintiff contends the ALJ improperly shifted to her the duty to fully and fairly develop the record when he relied upon the absence of treatment records from Dr. Mullozzi as a reason to discount plaintiff's assertion that she had been treated by the psychologist from August 1991 through March 31, 1996. Yet plaintiff's representative stated at the hearing that she was aware of no medical records that were not in the file except the most current records from plaintiff's treating physician, which she acknowledged were probably not material because they were outside the relevant time period. AR 740. Further, plaintiff testified at the hearing that she had not received any counseling or therapy for psychiatric problems on a regular basis. AR 763-64. Thus, by all accounts, there were no records from Dr. Mullozzi beyond those that were already in the record.

Even a letter in the record written by Dr. Mullozzi on November 17, 1997, does not support plaintiff's ethereal claim that additional records exist. In his letter, Dr. Mullozzi stated that plaintiff had recently granted him permission to disclose their "sessions," which began August 12, 1991, through May 15, 1997. However, in the next sentence, he indicates that the only records that he had not yet disclosed were those from 1991, explaining that "[plaintiff] has been reluctant until now to allow me to disclose my diagnoses and therapy sessions with her in 1991, for fear that her family members will learn of it and will further abuse her." AR 603. In the letter, Dr. Mullozzi then proceeded to explain a session that he had with plaintiff on August 12, 1991, at which time he diagnosed her with delayed post-

traumatic stress disorder with depression. Dr. Mullozzi did not indicate in his letter that records existed of any therapy sessions except the August 12, 1991 session he had described.

In order to rebut the finding that the ALJ developed the record fully and fairly, plaintiff must show that there is a prejudicial gap in the evidence. *Binion*, 13 F.3d at 245. Plaintiff cannot make this showing. Even now, when she has the benefit of counsel, plaintiff has not submitted the putative "missing" records from Dr. Mullozzi or even explained what they might contain, much less averred that they actually exist. "Mere conjecture or speculation that additional evidence might have been obtained in the case is insufficient to warrant a remand." *Id.* at 246.

As other evidence of an evidentiary gap, plaintiff argues that her representative failed to conduct a thorough cross-examination of the vocational expert that would have shown that the jobs he identified were beyond plaintiff's ability. Plaintiff argues that had her representative looked at the *Dictionary of Occupational Titles* (DOT) manual, she would have discovered that some of the jobs cited by the vocational expert in response to the ALJ's hypothetical limiting plaintiff to sedentary work were actually in the light exertional category. Yet plaintiff's representative raised this very argument in her post-hearing brief and the ALJ spent one and a half pages of his decision analyzing it. *See* AR 32-33. Plaintiff's contention that her representative did not represent her effectively is incorrect.[2]

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[2] Under the regulations in effect at the time, the ALJ's conclusion was proper. *See Powers v. Apfel*, 207 F.3d 431, 436 (7th Cir. 2000) ("Even if [the vocational expert's] testimony were considered to contradict the description of sedentary work in the Dictionary of Occupational Titles . . . a hearing officer is entitled to rely on expert testimony that contradicts such authorities"). The agency has promulgated a new rule that requires the ALJ to ask the vocational expert about testimony that may conflict with the DOT, but that rule applies to hearings held after December 4, 2000. Soc. Sec. Ruling 00-4p, 2000 WL 1898704 (S.S.A.) (Dec. 4, 2000).

Finally, plaintiff contends that her representative was to blame for an evidentiary gap when she submitted additional medical records from Dr. Ernest Peaslee to the ALJ after the hearing "without even as much as tying them into the case and stating her theory in a closing memorandum." Plaintiff's Brief in Support, dkt. 14, at 20. Although plaintiff asserts that Niemi submitted these records to the ALJ about one month before he issued his decision, there is nothing in the record to support this assertion. The record reflects only that the documents were submitted to the Appeals Council, which concluded that although material, the additional records did not provide a basis for changing the ALJ's decision.

Nonetheless, even assuming that Niemi either did not submit the records or that she did submit them but failed to "tie them into the case," the records do not establish an evidentiary gap. The records show that plaintiff saw Dr. Peaslee on August 17, 1995 to establish primary care with him. Dr. Peaslee took a medical and personal history from plaintiff, recorded her subjective complaints (plaintiff reported she spent quite a bit of time in bed or a chair) and diagnosed her with "rheumatologic symptoms felt secondary to severe fibromyalgia," a "history of moderate deafness" and other impairments noted by the ALJ in his decision. Approximately a month later, Dr. Peaslee prescribed Prozac. Plaintiff did not see Dr. Peaslee again until November 26, 1997.

Although some of the records from Dr. Peaslee do pertain to the relevant time period, they do not provide any evidence that was not already included in other documents in the record. Dr. Peaslee did not diagnose plaintiff with any new conditions nor render an opinion

regarding plaintiff's ability to work. Further, the record before the ALJ already contained evidence indicating that plaintiff had been prescribed Prozac: on February 27, 1996, plaintiff told her treating physician, Dr. Peterson, that her depressive symptoms had improved from the Prozac and she wondered if she could stop taking it. AR 438. Also, plaintiff testified at the hearing that she had taken Prozac for a while. Accordingly, the absence of Dr. Peaslee's records did not give rise to a gap in the evidence requiring remand.

III. Additional Evidence

As further evidence of an evidentiary gap, plaintiff submits approximately 40 pages of medical records that her representative did not submit at the administrative hearing. With the exception of reports that indicate that plaintiff fell and hurt her ankle in January 1998, most of the additional medical records are from 1987-1991. Plaintiff contends that this court must remand the case to the agency pursuant to sentence six of 42 U.S.C. § 405(g) for consideration of this additional evidence.[3]

To obtain a remand under sentence six of § 405(g), a plaintiff must show that "there is new evidence which is material and that there is good cause for the failure to incorporate such evidence into the record in a prior proceeding." 42 U.S.C. § 405(g). For sentence six

[3] Post-hearing counsel submitted these records to the Appeals Council. The Council determined that these documents were immaterial because they were outside the relevant time period covered by plaintiff's claim. This court owes no deference to the Appeals Council's materiality determination. *See Eads v. Secretary of Dept. of Health and Human Services*, 983 F. 2d 815, 817 (7th Cir. 1993); *Nelson v. Bowen*, 855 F.2d 503, 506 (7th Cir. 1988) ("The Appeals Council's determination that the additional evidence submitted by [plaintiff] is not material is a legal determination and therefore subject to de novo review").

purposes, "materiality" means that there is a "reasonable probability" that the Commissioner would have reached a different conclusion had the evidence been considered. *Perkins v. Chater*, 107 F.3d 1290, 1296 (7th Cir. 1997). "New" means evidence "not in existence or available to the claimant at the time of the administrative proceeding." *Id.* (citation omitted).

Plaintiff cannot make this showing. Plaintiff contends that the pre-onset date documents are material because they "illustrate Plaintiff's long history of back and left knee pain and detail her surgical treatments for such conditions." Plaintiff's Brief in Support, dkt. 14, at 23. However, the latest of these documents is from November 30, 1992, well over one year before the date on which plaintiff alleged she became disabled. Further, the ALJ found specifically that plaintiff suffered from degenerative changes in the back and knee and that she suffered pain from these impairments. The records do not show anything that would have been reasonably likely to change the outcome of the proceedings.

Plaintiff also contends that the additional medical records would have changed the outcome because they contain records showing that plaintiff attended physical therapy for her knee and back with no beneficial results. Plaintiff argues that this evidence refutes the ALJ's finding that plaintiff's lack of compliance with physical therapy detracted from the credibility of her complaints regarding her knee and back pain. I am not persuaded that this evidence would have made any difference to the outcome. Not only does the evidence showing that plaintiff attended physical therapy pre-date plaintiff's claimed onset of

disability by approximately two years, but the ALJ did not rely solely on plaintiff's lack of compliance with physical therapy for discounting her complaints of back and knee pain. The ALJ also noted that plaintiff did not use a cane or brace and her doctors had not recommended surgery. Further, he accounted for her complaints of knee and back pain by reducing her residual functional capacity to jobs requiring no kneeling, crawling, use of ladders or climbing stairs; very little or occasional stooping and crouching; and no lifting from the floor in a standing position.

The records dated after plaintiff's date last insured are also not material. Not only do they fall far outside the relevant time period, but they have nothing to do with plaintiff's claim. The records indicate that plaintiff fell inside her home when she was walking in the dark and stepped in a hole where a heat vent cover had been removed. *See id*., Exh. A, p.36. There is nothing in the records to suggest that plaintiff's failure to see the hole or her resulting fall was anything other than an accident unrelated to her impairments.

Finally, plaintiff contends that the additional evidence included additional radiographic studies of her back condition that could have changed Dr. Hammarsten's testimony. Plaintiff has waived this argument by failing to raise it until her reply brief. *See United States v. Turner*, 203 F.3d 1010, 1019 (7th Cir. 2000) (arguments raised for first time in reply brief are waived). Even if this court were to consider this argument, it would not change my recommendation. Dr. Hammarsten found that although plaintiff had hypertrophic changes throughout her spine, degenerative arthritis in the thoracic spine and

slight narrowing of the L3 interspace, she would not meet the listings for a back condition because her back condition was not accompanied by the necessary neurological findings. AR 738. Because the additional radiographic evidence submitted by plaintiff simply confirms the existence of degenerative changes and does not show any neurological findings, it would not have made any difference to the outcome of the proceedings.

IV. Plaintiff's Subjective Complaints

Plaintiff contends the ALJ failed to evaluate properly her subjective complaints regarding her pain and limited ability to perform various activities. The ALJ found plaintiff credible to the extent she alleged that she suffered from "a degree of pain" and physical and mental limitations, but found that the record as a whole did not support her contention that she was so disabled as to be unable to perform any competitive employment. Although plaintiff's arguments are somewhat difficult to discern from her brief, it appears that she is contending that by finding her not disabled, the ALJ improperly concluded that fibromyalgia cannot be a disabling impairment. Of course, if the ALJ had found that fibromyalgia can never be a disabling impairment, this court would have to send this case back to the agency for reevaluation. *See generally Sarchet v. Chater,* 78 F.3d 305 (7th Cir. 1996). But the ALJ did not so find. To the contrary, after concluding that plaintiff had fibromyalgia and that it caused her pain and other symptoms, the ALJ proceeded to evaluate the credibility of her

contention that those symptoms were so severe by March 31, 1996 that they prevented her from performing all work.

As the court explained in *Sarchet*, "[s]ome people may have such a severe case of fibromyalgia as to be totally disabled from working . . . , but most do not and the question is whether [plaintiff] is one of the minority." *Id.* at 307. To answer this question, the ALJ evaluated the medical evidence and the credibility of plaintiff's complaints. As the regulations instruct, the ALJ considered plaintiff's prior work record; observations of third parties and treating and examining physicians; daily activities; duration, frequency and intensity of the pain or other subjective symptoms; precipitating and aggravating factors; dosage, effectiveness and side effects of medications; and functional restrictions. 20 C.F.R. § 404.1529. The ALJ discussed each of these factors in detail in his decision and explained how he was weighing the evidence. Contrary to plaintiff's assertion, the ALJ did not rely solely on the lack of supporting medical evidence as a reason to discount her complaints, but cited this factor as one of several that weighed against her.

This court may not overturn the ALJ's credibility determination unless convinced that it is patently wrong or rests on objective factors or "fundamental implausibilities" that have no support in the record. *Herron v. Shalala*, 19 F.3d 329, 335 (7th Cir. 1994). Plaintiff argues that the ALJ ignored various pieces of evidence that support her complaints of disabling pain, including the fact that she participated in a pain control group in 1991; her husband's testimony that plaintiff could no longer read in March 1994 due to poor eyesight

associated with fibromyalgia and that he built an addition on their home in 1997 so she would no longer have to climb stairs; plaintiff's testimony that she takes Darvocet when her pain is very bad and some days she cannot get out of bed because of pain; and plaintiff's medical records showing a diagnosis of fibromyalgia and a "lengthy history" of treatment for pain complaints.

But the ALJ's written opinion need not evaluate every piece of testimony and evidence submitted. A review of the ALJ's decision shows that he reviewed plaintiff's medical records in detail, including those pertaining to her fibromyalgia and her various complaints of pain. The ALJ acknowledged that plaintiff's condition may have progressed to the point that she was disabled at the time of the hearing; however, the question before him was whether plaintiff's condition had reached that point on or before March 31, 1996. Because of the limited scope of the ALJ's inquiry, it was not necessary for him to discuss evidence that did not relate to that time period, such as plaintiff's testimony regarding her use of Darvocet and her husband's testimony regarding the house addition. Moreover, the ALJ specifically noted plaintiff's husband's testimony, concluding that although the man was a sincere witness, his testimony carried less weight because he did not have specialized medical training, but he did have a financial incentive for seeing that his wife received benefits. Finally, because the evidence that plaintiff attended a pain clinic in 1991 was three years before her alleged date of onset and was supported by minimal documentation in the record, the ALJ did not err by failing to discuss this evidence.

Plaintiff also contends that the only "major factor" upon which the ALJ relied for his credibility determination was the fact that plaintiff failed to participate in a fibromyalgia program recommended by her doctor. The ALJ acknowledged that plaintiff told her doctor that she was not interested in the program because her insurance would not cover it, but found this explanation inadequate in light of plaintiff's husband's disability income of $1,600 a month and the absence of evidence indicating that plaintiff had been denied treatment because of financial hardship or that she had sought out low-cost treatment. Plaintiff contends this was an improper basis for rejecting plaintiff's credibility because the ALJ never questioned plaintiff about the cost of the fibromyalgia program or her family's budgetary needs.

Even if I accept plaintiff's contention that the ALJ drew conclusions about her financial situation that were not supported adequately by the record, it would not change my conclusion that the ALJ's credibility determination was proper. Plaintiff's failure to participate in the fibromyalgia program was only one of several reasons articulated by the ALJ for discounting her subjective complaints. Other reasons included her reported activity level in March 1995, her husband's testimony that her condition deteriorated after 1996, medical records from July 1995 that indicated that plaintiff's fibromyalgia symptoms were fairly well-controlled with medication, the lack of evidence of mental health treatment and Dr. Hammarsten's testimony that a person with plaintiff's conditions and limitations could perform a limited range of work. Plaintiff does not challenge any of these other bases for the

ALJ's credibility determination. Because these other reasons were supported adequately by evidence in the record, the ALJ's credibility finding was proper. *See Herron*, 19 F.3d at 336.

V. Evaluation of Mental Impairment

Plaintiff contends that the ALJ evaluated her mental impairments improperly. The method for evaluating mental impairments is explained in 20 C.F.R. § 404.1520a. First, the ALJ must determine whether the claimant has a medically determinable mental impairment. 20 C.F.R. § 404.1520a (3). If a medically determinable mental impairment exists, the ALJ then must rate the degree of functional limitation resulting from the impairment in four broad categories: activities of daily living; social functioning; concentration, persistence or pace; and episodes of decompensation. 20 C.F.R. § 404.1520a (4). The degree of functional loss in each category is important to identifying the severity of the impairment. Claimants who are found to have "none" or "mild" functional loss are generally found not to have a severe mental impairment. If the claimant has a severe mental impairment, then the ALJ must compare the degree of functional loss in each category to the listings to determine whether the claimant meets the criteria for a listed mental impairment. *Id.* (In general, those who have "marked," "frequent" or "extreme" functional loss in two or more categories will meet the criteria for a listed impairment.) If the claimant has a severe mental impairment that does not meet the listings, then the ALJ must evaluate residual functional capacity (RFC) by considering "an expanded list of work-related capacities that may be

affected by mental disorders . . . ." *See* 20 C.F.R. § 1520a(c)-(d); 20 C.F.R., Pt. 404, Subpt. P, App. 1, Rule 12.00A. (discussing steps for evaluating mental impairments). Although this "expanded list" is not described in the regulations, the Commissioner has a "Mental Residual Functional Capacity Assessment" form (SSA-4734-F4-SUP) that lists 20 work-related functions that are to be rated. The signature line on the form indicates that the form is to be signed by a medical consultant.

Plaintiff contends that this case must be remanded to the Commissioner because the ALJ did not make a finding as to each of the specific work-related categories identified by the Commissioner on Form SSA-4734-F4-SUP. However, I have not located and plaintiff does not cite any authority for her contention that the ALJ must use this form when evaluating mental RFC. In the absence of such authority, I am unable to conclude that this case must be remanded for completion of a mental RFC form. Further, contrary to plaintiff's suggestion, the ALJ *did* assess plaintiff's mental residual functional capacity, concluding that she could perform simple, unskilled work requiring only three-to-four step instructions with brief and superficial contact with the public and no high production goals or quotas. Clearly, these limitations on plaintiff's ability to work relate to the mental demands of the job.

Plaintiff contends that to the extent the ALJ did assess her mental RFC, his assessment was incomplete because it did not include his finding that plaintiff "often" had deficiencies in concentration, persistence or pace. Instead, argues plaintiff, the ALJ appears to have attempted to account for plaintiff's deficiencies in this area by limiting her to "simple

and unskilled" work. Plaintiff contends that by posing his hypothetical question to the vocational expert in this fashion, the ALJ's question "answered itself" and omitted a "crucial step" in the analysis.

I disagree. First, plaintiff cites no authority for her contention that the ALJ's hypothetical question must track exactly the limitations from the PRTF. To the contrary, because the mental residual functional capacity assessment is more specific than the assessment of listing severity, it was *more* appropriate for the ALJ to have incorporated his specific mental residual functional capacity finding–simple, unskilled work requiring only three-to-four step instructions with brief and superficial contact with the public and no high production goals or quotas–than the broader finding from the PRTF. As the Commissioner notes, a finding that a claimant "often" has deficiencies of concentration, persistence or pace is not necessarily inconsistent with a finding that there are jobs she can perform. *See Nelson v. Apfel*, 210 F.3d 799, 802 (7th Cir. 2000) (medical expert's finding that claimant "often" had deficiencies of concentration, persistence and pace would not preclude ALJ from finding that claimant's functional loss had no more than minimal effect on ability to work). Here, the ALJ properly accounted for plaintiff's concentration and pace deficiencies by limiting her to simple, unskilled work with no high production goals or quotas.

Second, it was not improper for the ALJ to have included "simple and unskilled" work in his hypothetical question.[4] Although the ALJ was to some extent making a vocational conclusion when he found that plaintiff could perform unskilled work, the hypothetical was not improper. A hypothetical question "must fully set forth the claimant's impairments to the extent that they are supported by the medical evidence in the record." *Herron v. Shalala*, 19 F.3d 329, 337 (7th Cir. 1994). A review of the transcript indicates that the ALJ presented a very detailed hypothetical question that included all of plaintiff's impairments, exertional limitations and non-exertional limitations. Significantly, although plaintiff contends that the ALJ "left out" limitations from his mental RFC assessment, she does not identify what those limitations are and does not point to any specific evidence in the record that would support additional limitations. In the end, plaintiff's argument circles back to her contention that the ALJ was required to make a finding with respect to every function listed on the "Mental Residual Functional Capacity Assessment" form. Although requiring ALJs to use the form would seem to promote uniformity in evaluating mental impairments, as noted previously, the Commissioner currently does not demand this documentation.

Plaintiff raises two additional challenges to the ALJ's evaluation of her mental impairments. First, she resurrects the issue of Dr. Mullozzi's records, contending that the

[4]The ALJ's findings that plaintiff could perform work that was "simple," "unskilled" and required "no more than three or four instructions" appear to be redundant. *See* 20 C.F.R. § 404.1568(a) ("Unskilled work is work which needs little or no judgment to do simple duties that can be learned on the job in a short period of time.")

ALJ should not have evaluated her mental impairments without first obtaining the "missing" records from Dr. Mullozzi. For the reasons stated previously in this report, this argument has no merit. Second, plaintiff contends that the ALJ improperly concluded that Desmonde's report was inconsistent with a finding of disability. Plaintiff points out that Desmonde noted that she reported limited days on which she was able to move around and that she complained of joint pain, depression and tiredness, and argues that this was consistent with her complaints of disabling limitations. However, as the ALJ noted, Desmonde did not find evidence of a significant mental impairment but diagnosed her as suffering only from a mood disorder and rated her ability to function in the past year as good. To the extent that Desmonde's conclusion may have been inconsistent with other aspects of his report, it was up to the ALJ to determine how to best resolve the inconsistency and this court must defer to his judgment.

In sum, the ALJ properly evaluated plaintiff's mental impairments as prescribed by the regulations and his conclusions are supported by substantial evidence in the record. This aspect of his decision should be affirmed.

VI. Hearing Loss and Obesity

The administrative record contains results of auditory testing performed on plaintiff in June 1994 and November and December 1996. Dr. Hammarsten testified that the results of the November and December 1996 testing showed hearing loss at levels high enough to

meet the listings. The 1994 tests showed that plaintiff had lost hearing, but not enough to meet the listings. Relying on this testimony, the ALJ found that plaintiff's hearing loss, though severe, did not meet the listings on or before March 31, 1996.

Citing to Social Security Ruling 83-20 ("SSR 83-20"), plaintiff contends that the ALJ committed legal error by failing to consider whether her hearing loss may have become severe enough to meet the listings at some point after June 1994 but before March 31, 1996. Under SSR 83-20, an ALJ evaluating a disability of nontraumatic origin, like plaintiff's hearing loss, is to consider three factors in determining the onset date: the applicant's allegations, work history, and medical and other evidence. Plaintiff argues that the ALJ's failure in his decision to include any analysis of the date of onset of plaintiff's hearing loss is reversible error.

It is true that the ALJ did not discuss in his decision the possibility that plaintiff had met the listings for hearing loss prior to March 31, 1996. But contrary to plaintiff's position, this is not grounds for remand. In order to meet the listings, plaintiff had to present evidence showing that her hearing loss was not restorable by hearing aids. 20 C.F.R. Pt. 404, subpt. P. app. 1. 2.08 (hearing impairment is determined by hearing loss not restorable by hearing aids). Although the audiologist who tested plaintiff's hearing in December 1996 opined that plaintiff's hearing aids were not adequate for her current hearing levels, he did not provide any measurements of plaintiff's ability to hear with the hearing aids. AR 500-506. Thus, although the ALJ accepted Dr. Hammarsten's testimony

that plaintiff met the listings as of November 1996, it appears that Dr. Hammarsten did not have enough evidence to make that conclusion because the measurements showed only plaintiff's hearing loss without hearing aids.

In his decision, the ALJ noted that he "observed the claimant's ability to hear with hearing aids and found that the claimant did not ask for questions or statements to be repeated at the hearing and was able to more than adequately hear questions asked by the undersigned and her counsel and respond appropriate[ly]." AR 26. Later in the decision, he found that "based on the record and personal observation," plaintiff could hear adequately with hearing aids. AR 28. Although the ALJ did not refer to specific documents or exhibits in the record, I presume he was referring to reports of contacts between disability examiners and plaintiff's treating physician, Dr. Peterson. Both Dr. Peterson and his office assistant indicated in April 1997 that they had not had any problems communicating with plaintiff, either in person or on the phone. AR 519-23. In addition, a nephrologist who evaluated plaintiff in January 1997 indicated that plaintiff "could hear me without me necessarily looking at her." AR 533. In the absence of medical evidence documenting the degree of plaintiff's hearing loss as of March 31, 1996, it was not improper for the ALJ to have relied on this evidence as well as his own observations as a basis for his conclusion that plaintiff's hearing loss was restorable by hearing aids. *See* SSR 83-20 (in cases involving progressive impairments and medical evidence does not establish precise date impairment

became disabling, ALJ must infer onset date from medical and other evidence, including lay evidence).

Plaintiff also contends the ALJ did not adequately account for her hearing loss in his hypothetical question to the vocational expert. The ALJ asked the vocational expert to assume an individual who, because of hearing loss, would be unable to work around unprotected, dangerous machinery. Plaintiff argues that by addressing her hearing loss in this manner, the ALJ ignored other vocational limitations, such as difficulty communicating with supervisors, co-workers or the public, that would be exacerbated by high noise levels likely to be found in a factory setting. However, the claimant bears the burden to establish residual functional capacity at step four of the sequential analysis. As just discussed, the ALJ found from the record and his own observations that plaintiff could hear adequately with hearing aids. Nonetheless, he asked the vocational expert to assume that plaintiff had some hearing loss. Plaintiff does not point to any evidence in the record that would support limitations beyond those found by the ALJ.

Harkening back to her contention that the ALJ failed to develop the record fully, plaintiff contends the ALJ failed to question her adequately regarding her hearing impairment. Although it is true that neither the ALJ nor plaintiff's representative asked her many questions about her hearing loss, I conclude that further questioning was unnecessary in light of the evidence in the record and the ALJ's ability to observe plaintiff's ability to hear and understand the questions being asked at the hearing.

Finally, I find no merit in plaintiff's contention that the ALJ did not adequately consider the effect of her obesity on her residual functional capacity. Relying on Dr. Hammarsten's testimony, the ALJ specifically noted obesity as one of her impairments but found that she retained the residual functional capacity for a limited range of work despite that impairment. Plaintiff does not point to any evidence in the record or explain how her obesity warrants any more limitations than those found by the ALJ.

VII. Conclusion

Plaintiff's medical records reveal a woman whose ever-worsening health deteriorated to the point that she is now disabled by a combination of painful physical and mental impairments. Unfortunately, entitlement to benefits is not dependent simply on the severity of one's impairment, but on timing as well. In this case, the ALJ determined, after a thorough review of the medical evidence and other evidence in the record, that despite her impairments plaintiff still was able to perform some jobs when the buzzer sounded on her period of insurability. For the reasons stated above, I conclude that his decision is supported by substantial evidence in the record. This court should deny plaintiff's motion for summary judgment and affirm the Commissioner's decision.

RECOMMENDATION

Pursuant to 28 U.S.C. § 636(b)(1)(B), I respectfully recommend that the decision of the Commissioner denying plaintiff Mary Kay Jones's application for disability insurance benefits be AFFIRMED.

Entered this 18th day of October, 2001.

BY THE COURT:

STEPHEN L. CROCKER
Magistrate Judge