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

ALLEN STARK,

Plaintiff,

v.

MICHAEL J. ASTRUE,
Commissioner of Social Security,

Defendant.[1]

OPINION AND ORDER

06-C-052-C

This is an action for judicial review of an adverse decision of the Commissioner of Social Security brought pursuant to 42 U.S.C. § 405(g). Plaintiff Allen Stark seeks reversal of the commissioner's decision that he is not disabled and therefore is ineligible for either Disability Insurance Benefits or Supplemental Security Income under the Social Security Act, codified at 42 U.S.C. §§ 416(I), 423(d) and 1382c (3)(A). Plaintiff contends that the decision of the administrative law judge who denied his claim at the hearing level is not supported by substantial evidence because the judge failed to fully evaluate plaintiff's medical condition, improperly weighed a physician's opinion, made a faulty credibility determination and relied on vocational expert testimony that was unfounded. (Plaintiff does not challenge any of the administrative law judge's findings regarding his mental condition

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[1] Michael Astrue was sworn in as Commissioner of Social Security on February 12, 2007. The case caption has been changed to reflect the new defendant.

or drug and alcohol abuse.) For the reasons set forth below, I am denying plaintiff's motion for summary judgment and affirming the administrative law judge's decision.

LEGAL FRAMEWORK

To be entitled to either disability insurance benefits or supplemental security income payments under the Social Security Act, a claimant must establish that he is under a disability. The Act defines "disability" as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months." 42 U.S.C. § 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 her past work? and

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

20 C.F.R. §§ 404.1520, 416.920.

The inquiry at steps four and five requires assessment of the claimant's "residual functional capacity," which the commissioner defines as "an assessment of an individual's ability to do sustained work-related physical and mental activities in a work setting on a regular and continuing basis." Social Security Ruling 96-8p. "A 'regular and continuing basis' means 8 hours a day, for 5 days a week, or an equivalent work schedule." Id.

In seeking benefits, the initial burden is on the claimant to prove that a severe impairment prevents him from performing past relevant work. If he can show this, then the burden shifts to the commissioner to show that the claimant was able to perform other work in the national economy despite the severe impairment. Stevenson v. Chater, 105 F.3d 1151, 1154 (7th Cir. 1997); Brewer v. Chater, 103 F.3d 1384, 1391 (7th Cir. 1997).

The following facts are drawn from the administrative record (AR):

FACTS

A. Procedural History

Plaintiff filed applications for Social Security Disability Insurance Benefits and Supplemental Security Income in 2001. AR 66-68. After the local disability agency denied his applications initially and upon reconsideration, plaintiff requested a hearing before an administrative law judge, which was held on October 26, 2004 before Administrative Law Judge Ira Epstein. Plaintiff was represented by counsel. The administrative law judge heard

testimony from plaintiff and from neutral medical expert Allen Hauer and neutral vocational expert Richard Willette. AR 308-9.

On May 17, 2005, the administrative law judge issued his decision, finding plaintiff not disabled. AR 13-28. This decision became the final decision of the commissioner on December 14, 2005, when the Appeals Council denied plaintiff's request for review. AR 5-7.

B. Background

Plaintiff was 46 years old on the date of his administrative hearing, making him a "younger person" for the purposes of his applications for disability benefits. AR 311; 20 C.F.R. §§ 404.1563, 416.963. In his disability report, plaintiff indicates that he completed twelfth grade, but he testified at his hearing that he has only an eleventh grade education. AR 85, 311. After high school, plaintiff joined the army but left after three weeks because he injured his ankle in basic training. AR 312-13. Subsequently, he worked off and on as a barge worker, janitor, machinist helper, seasonal agricultural laborer, lumberyard worker and construction worker until he stopped working altogether on May 8, 2001. AR 72-3, 75, 79-80, and 86.

In early 2003, plaintiff was charged with battery and bail jumping. Plaintiff was transferred to the Mendota Mental Health Institute on March 12, 2003, for inpatient evaluation of his competency to stand trial. AR 209, 266. On April 4, 2003, he was ordered to remain at Mendota for treatment "to competency." AR 209, 273. Plaintiff was

discharged on August 11, 2003 and subsequently incarcerated until February 2004. AR 209, 311.

C. Medical Evidence

On December 14, 1998, plaintiff visited the outpatient facility at the Veterans Administration Medical Center in Tomah, Wisconsin (Tomah Center) where he was examined by Dr. Dale Wicklund for chronic problems with his right ankle. Plaintiff reported that he was medically discharged from the army after he sustained the injury in basic training. Dr. Wicklund noted that plaintiff suffered from swelling and pain, some abnormal gait and problems with other joints, probably because of splinting. According to Dr. Wicklund, x-rays showed some degenerative changes of calcification between the lateral malleous and the talus and some abnormality of the joint space. Dr. Wicklund referred plaintiff for an orthopedic consultation at the William S. Middleton Memorial Veterans Hospital in Madison, Wisconsin (Madison Center); encouraged him to get "service connected", and gave him Ibuprofen. AR 140 and 189.

There is no record of further treatment until October 8, 1999 when plaintiff saw Dr. Maynard Pang at the Tomah Center. AR 135-39 and 189. Plaintiff told Dr. Pang that he continued to experience pain, for which he takes Motrin. Plaintiff walked with a limp. Plaintiff reported and Dr. Pang observed some swelling in the right ankle, with restricted range of motion on flexion and extension. Dr. Pang noted that there was an obvious

deformity on plaintiff's ankle but no erythema abnormal redness of skin) or pain on palpation. Dr. Pang suspected that either a hairline fracture or cartilage damage was causing the pain. Dr. Pang referred plaintiff to the orthopedic clinic in Madison, prescribed Percocet (14 tablets to be taken only at night), instructed plaintiff to use crutches and not put weight on his right ankle until he saw the orthopedic doctors and asked plaintiff to follow up with Dr. Wicklund in three months. AR 135.

Plaintiff visited the orthopedic clinic at the Madison Center on October 26, 1999, and reported that his pain had been progressive and was present with activities. Plaintiff stated that he had intermittent swelling in the ankle and was having extreme difficulty working as a janitor. Dr. Michael Lamson observed tenderness along the length of the right posterior tibial tendon to its insertion and minimal subtalar motion. Plaintiff also had pain with resisted plantar flexion and inversion, was unable to complete a single heel rise, and had a positive "too-many-toes sign." Three x-ray views revealed some talar breaking and a possible old medial malleolar fracture and distal fibular fracture. There were no significant degenerative changes with the tibiotalar joint and no appearance of a bony coalition. Dr. Lamson stated that the pain was likely secondary to posterior tibial tendon dysfunction but that he could not rule out tarsal coalition. Dr. Lamson ordered a computed tomography (CT scan) and an orthotics consultation for a shoe insert. AR 187.

On November 30, 1999, plaintiff visited the Tomah Center after he fell off the roof at work that morning, hitting his head, right hand and right elbow. X-rays revealed that plaintiff had fractured his right hand. AR 133-34. Plaintiff returned to the Tomah Center

on December 2, 1999, reporting that he was in unbearable pain and had missed his ride to the Madison orthopedic clinic. He was given a limited supply of Percocet for pain. AR 132. The next day (December 3, 1999), plaintiff visited the Madison Center for his hand injury, and Dr. Lamson noted that plaintiff had "been ambulating without difficulty." AR 185. Dr. Lamson placed plaintiff's hand in a cast and noted that plaintiff still needed a CT scan of his ankle and required an orthopedic appliance for his posterior femoral stress syndrome. AR 185.

Plaintiff returned to the Tomah Center on February 8, 2000 after missing a previous appointment at the Madison Center orthopedics clinic because of a snow storm. AR 130-31. Plaintiff told the nurse that his ankle continued to cause him much pain and rated the pain an 8. AR 131. Plaintiff was limping and reported a problem with the upper part of his lower leg and aching in other joints as he limps. Dr. Wicklund noted that plaintiff had been on multiple medications but that "apparently the nonsteroidals do not do much good for him." He prescribed Darvon and noted an upcoming appointment in Madison. AR 130.

On March 21, 2000, plaintiff saw a physical therapist at the Madison Center who fit him with a short leg walking boot that he was to wear for four weeks. The therapist noted that plaintiff complained of "severe L foot and ankle pain" and was not sleeping well because of increased pain intensity. The therapist observed that plaintiff had an "antalgic gait pattern" (I assume this refers to a gait designed to avoid pain),"limited L talocrural and

subtalar mobility," and strength rating at 5/5 for the right ankle and foot prime movers and 4/5 for the left. AR 183.

On May 11, 2000, plaintiff called the Madison Center and spoke with a nurse about intermittent dull/sharp pain in his right ankle radiating up to his knees that was aggravated by standing or walking. Plaintiff said he was having difficulty meeting the walking requirements of his new job. He was experiencing tingling at night, as well as swelling, which was worse during the day. He stated that he had been using the padded boot and that it gave him some relief. He reported that soaking his ankle and taking 800 mg of Motrin bid was not relieving his pain. He requested an appointment and the nurse forwarded his request to orthopedics. The nurse told him to continue following the instructions that orthopedics had given him. AR 181.

Plaintiff next saw Dr. Wicklund at the Tomah Center for a followup visit on August 10, 2000. Dr. Wicklund noted that his "old traumatic injury with degenerative disease is now affecting his low back and his knee because of limping" and continued him on Darvon as needed. AR 129.

Six months later, on February 16, 2001, plaintiff saw Dr. Boyd Lumsden at the Madison Center for a followup and second opinion. Plaintiff reported that his ankle was painful on a daily basis and has been getting progressively worse over the years. Plaintiff also reported that his ankle pain had a significant impact on his life, most recently requiring him to quit a factory job because of his inability to tolerate prolonged standing or other activities.

He denied numbness, tingling or instability in the foot. Plaintiff reported occasionally taking Ibuprofen for his pain. Upon examination, Dr. Lumsden observed plaintiff had pes planus bilaterally and "too many toes sign" bilaterally when standing with a mild degree of valgus deformity in both feet. Plaintiff was unable to toe walk or perform either a single or double heel rise on the right. He could perform a double heel rise on the left only with assistance and was not able to "dorsiflexion against gravity." Plaintiff had significant pain with resisted attempts at inversion and plantar flexion but no pain with ankle dorsi- or plantar flexion on the right side. His right hindfoot was fixed and would not invert. Motor power testing revealed that plaintiff's right plantar flexion of his posterior tibia in inversion was 1/5 and anterior tibia was 2/5. The circulatory, motor and sensory exams on the right foot were normal. AR 178. X-rays revealed pes planus, talonavicular arthritis, subtalar arthritis, a fixed valgus deformity to his hindfoot and an old lateral malleolar fracture. AR 179.

After diagnosing plaintiff with bilateral posterior tibial dysfunction stage 3 on the right and stage 1-2 on the left, Dr. Lumsden discussed non-surgical and surgical options at length with plaintiff. Plaintiff reportedly never obtained the previously recommended orthosis because he thought that it would not help and he was not interested in surgical options. Dr. Lumsden told plaintiff these were the only two available options and it was unlikely plaintiff would receive disability if he chose not to pursue the recommended options. Dr. Lumsden referred plaintiff to physical therapy to be fitted with a custom molded shoe insert. Dr. Lumsden stated that it was unlikely that conservative measures

would fix the ankle problem or make it less debilitating. He also expressed the opinion that the ankle injury was related to plaintiff's past service injury, but that plaintiff's other more systemic complaints (back pain and other) were not related to that past injury. AR 179.

Plaintiff saw a physical therapist on March 5, 2001 at the Madison Center about the shoe insert and was referred to an orthotic center to have the mold prepared. Plaintiff reported that he could hardly walk and his pain ranged from 6-7 out of 10. AR 169-74. Upon recommendation of the orthotist on March 16, 2001, the shoe insert was changed to a splint to provide better pain relief. AR 176.

On April 17, 2001, plaintiff returned to the Madison Center to see Dr. Brian Koch for routine evaluation. Plaintiff told Koch that the splint made his foot feel better at times but did not fit him well, causing him foot, knee and hip discomfort. Dr. Koch's physical examination revealed no changes from Dr. Lumsden's prior notes. Although Dr. Koch re-emphasized operative versus nonoperative treatment, plaintiff continued to decline surgery. Dr. Koch ordered modifications to plaintiff's splint and stated that if plaintiff did well, he could progress to other types of orthotics. AR 202-204.

On May 18, 2001, plaintiff saw the physical therapist for a followup on the splint and reported continuing pain in his foot and hip. Plaintiff did not believe the splint was decreasing his pain but indicated that it provided more support and stability. Plaintiff rated his pain as a 7 out of 10 and presented with an antalgic gait. He agreed to try anti-shock

shoe inserts, which felt better on trial, and a cane. The physical therapist noted that plaintiff's splint needed further adjustment. AR 201.

Plaintiff visited the Madison Center for a follow up on July 17, 2001, reporting that he had stopped using the splint because it was more irritating than helpful. Plaintiff also reported that the shoe insert was moderately helpful. Sue Ellen Eugster, a nurse practitioner, re-emphasized operative versus nonoperative treatment options, but plaintiff was not interested in discussing further bracing or surgery. Plaintiff complained of generalized muscle and joint pain that limited his ability to work or rest at night. He also reported cramping, low energy and depression. Eugster noted that examination of plaintiff's ankle remained unchanged from the prior visit but she expressed concern that plaintiff might have "a more systemic process occurring / possibly fibromyalgia." Eugster referred plaintiff to rheumatology for further evaluation. AR 196-98.

On August 6, 2001, plaintiff returned to Tomah Center for an annual preventive health screening and a followup on his ankle pain. In the health screening, plaintiff reported shooting pain from his right ankle up to his knee; pain in his back, joints and muscles (he was bitten by a tick four times in the spring); and rated his pain at 8. AR 122. Plaintiff reported to Dr. Wicklund that he had pain all over his body but most severely in his hips and low back. His ankle had been "giving him a lot of trouble" and Ibuprofen was not helping the pain. Plaintiff reported drinking fair amounts of alcohol and he said that his mother and friends were bringing him food because he no longer had a driver's license. Dr.

Wicklund diagnosed chronic pain syndrome with degenerative disease in the ankle and noted that he did not have the orthopedic reports. Dr. Wicklund prescribed Arthrotec and ordered laboratory tests for sedimentation rate, lyme titer, rheumatoid and antinuclear antibodies. AR 127.

On October 4, 2001, Dr. P. Chan, a state disability agency consulting physician, completed an assessment of plaintiff's physical residual functional capacity. AR 141-48. He concluded that plaintiff could lift/carry 10 pounds occasionally and less than 10 pounds frequently and could stand or walk or both for a total of two hours and sit for a total of six hours in an eight-hour work day. He also found that plaintiff was unable to use foot controls on the right side. On April 22, 2002, another state disability agency consulting physician reviewed the medical evidence in plaintiff's file and the residual functional capacity form and signed the 2001 form without changes.

On October 29, 2001, plaintiff saw Dr. Eric Gowing in the rheumatology clinic at the Madison Center. Plaintiff reported a 24-year history of bilateral ankle pain and a 20-year history of low back pain. He indicated that his ankle disability was the main reason for his unemployment because he was unable to bear weight for any significant length of time. Plaintiff reported having no stiffness or pain at rest, no history of joint swelling or stiffness in hands and wrists, and no symptoms in the neck and shoulders. Plaintiff stated that he used 600 mg of Ibuprofen as needed, which helped somewhat. He rated his pain a 7. Dr. Gowing wrote that plaintiff hobbled into the exam room and had tenderness in his lumbar paraspinal region upon palpation. Plaintiff was able to perform a straight leg raise on the

right side to only 60 degrees before he was in pain. He had no swelling in his ankles but exhibited decreased inversion and eversion and pain upon subtalar stress. Dr. Gowing ordered x-rays and prescribed 50 mg indomethacin three times daily as needed. AR 193. X-rays of the right knee and spine were normal. AR 167-68. At a November 7, 2001 followup visit with Dr. Gowing, plaintiff rated his ankle pain an 8 and reported that the Indocin did not reduce the pain. He also reported not using his cane or a crutch. Dr. Gowing noted plaintiff's right ankle had diffuse tenderness and synovitis and ordered a chest x-ray and laboratory tests for his musculoskeletal complaints. AR 162, 190.

On December 20, 2001, plaintiff received magnetic resonance imaging of his right foot and ankle to rule out subtalar joint arthritis. AR 160, 166-67. The magnetic resonance imaging showed severe degenerative changes in the middle facet of the ankle joint, but the ligament structure and soft tissues were normal. AR 166-67.

On January 16, 2002, plaintiff had a followup appointment at the rheumatology clinic. Dr. Gowing wrote that plaintiff left his November 2001 appointment without getting his chest x-ray or laboratory tests. Dr. Gowing explained to plaintiff that they still did not have a diagnosis for his musculoskeletal complaints and that plaintiff had to undergo the ordered tests. AR 162. During a January 30, 2002 followup visit with Dr. Gowing, plaintiff reported pain in his wrists, elbows, knees, hips and ankles with prolonged stiffness for hours in the mornings. Plaintiff tested positive for Lyme Disease. Dr. Gowing noted that plaintiff's Lyme Disease had been active for nine months without treatment. Plaintiff stated that he first learned of the Lyme Disease in the summer of 2001. Dr. Gowing prescribed

100 mg doxycycline twice daily for two months and noted that some of plaintiff's "symptoms may be related to fibromyalgia which is associated with Lyme Disease and may not respond to treatment with doxycycline." With regard to plaintiff's ankle, Dr. Gowing noted no synovitis or swelling. AR 159.

Six months later, on July 29, 2002, plaintiff saw a resident, Dr. Julie Hildebrand, in the rheumatology clinic at the Madison Center. Plaintiff reported continuing debilitating pain and fatigue, unchanged swelling and pain in his right ankle and pain in his low back. Plaintiff reported that prolonged sitting, standing or ambulation caused more pain and that he slept poorly because of low back and ankle pain. Plaintiff reported that he was unable to maintain any employment and asked Dr. Hildebrand to complete a medical application for social security benefits. Dr. Hildebrand did not complete the form because it related to rheumatoid arthritis, which plaintiff did not have. Instead, Dr. Hildebrand answered the questions in her progress notes. She indicated that plaintiff had had rheumatology appointments every 2-3 months since October 2001 and had been diagnosed with "Lyme Disease (treated)" and severe degenerative arthritis of the ankles and lumbar spine. Dr. Hildebrand wrote that plaintiff "will likely not recover function from his current state." AR 155.

Dr. Hildebrand indicated that plaintiff had chronic pain/paresthesia, including: 1) frequently occurring, sharp, throbbing pain in the low back (L4-S1) rated 8/10 in severity and 2) frequently occurring, sharp pain bilaterally in the anterior calf/shin rated 8/10 in severity. Regarding impairments, she observed the following signs: straight leg raising at 90

degrees on the left and 60 degrees on the right, muscle weakness of 4+/5 plantar and dorsiflexion bilaterally, antalgic gait, chronic fatigue, tenderness of lumbar paraspinal muscles and pain upon subtalar stress bilaterally, impaired sleep, and reduced grip strength. Dr. Hildebrand reported lumbar spine range of motion as 50% of normal on extension and flexion, 15% of normal on lateral flexion (right and left), and 25% of normal on rotation. Ankle range of motion was reported as 30 degrees plantar flexion and dorsiflexion bilaterally and 50% of normal on eversion and inversion. Cervical range of motion was reported as normal. Dr. Hildebrand repeated the results of the December 2001 magnetic resonance imaging and noted that lumbar spinal films were taken in March 2002 (no other record is present on this), which showed degenerative changes predominating at L2-3. AR 156.

Dr. Hildebrand noted that plaintiff's pain and fatigue would interfere with his attention and concentration to perform even simple work tasks on a daily basis for two to three hours. She further indicated that fast-paced tasks and exposure to work hazards in the workplace at a competitive job would likely exacerbate his symptoms. She reported that plaintiff's impairments had lasted more than 12 months but he had no side effects from medications with implications for working. In Dr. Hildebrand's opinion plaintiff had the following work restrictions: no walking; sit 30 minutes at one time then must stand; stand 30 minutes at one time then must sit; sit and stand or walk for a total of about two hours in an eight hour work day; with prolonged sitting, he would need to elevate his legs six inches; if he had a sedentary job, his legs should be elevated 50% of an eight-hour day; unscheduled daily breaks of 15 minutes; use of a cane while engaging in even occasional

standing or walking; lift less than 10 pounds occasionally and never 10 pounds or over; never twist, bend or stoop. She indicated plaintiff had no significant limitations with reaching, handling or fingering but then stated he had muscle cramps in his hands and shoulder pain causing limitations. She estimated plaintiff could use his arms for reaching 50% of the time during an eight-hour work day. AR 156-57.

Dr. Hildebrand wrote that plaintiff was likely to be absent from work about four days a month as a result of his impairments. She also noted that some of his symptoms "may be related to fibromyalgia which is associated with Lyme disease (fatigue)" and that he is likely depressed due to his disability. She prescribed 20 mg paroxetine daily for possible depression. AR 158. Following plaintiff's visit to Dr. Hildebrand in July 2002, there is no record that plaintiff received further treatment for his physical symptoms before the hearing date in 2004.

On March 5, 2003, plaintiff was court-ordered to undergo an evaluation of his competency to stand trial for criminal charges. Ed Musholt, Ph.D. evaluated plaintiff initially in jail on March 11, 2003. In his March 25, 2003 report to the Jackson County Circuit Court, Dr. Musholt reviewed plaintiff's past mental health records. Those records showed that during his 30's, plaintiff was on probation and may have been ordered to go to counseling, which he did not do. Mental health records from 1995-1996 reported that Dr. Krohn observed plaintiff limping severely with his foot during their office visit, but when plaintiff crossed the street on his way to the hospital, Dr. Krohn could see no limp. In a January 31, 1996 clinical record, Dr. Whitehead wrote: "I do wonder about his use of

conning, irresponsibility and possible impulsivity." During plaintiff's hospitalization for depression at the Tomah Center in January 2003, it was noted that "Patient's symptom's [sic] show some inconsistency and I question if there is an element of embellishment." AR 266-68.

Dr. Musholt noted that when he switched from diagnostic to competency related questions during a March 11, 2003 interview, plaintiff became less responsive. Initially Dr. Musholt believed that plaintiff was trying to appear incompetent but later learned plaintiff's psychiatric medications may have had a sedating effect. Dr. Musholt also found plaintiff non-responsive during a March 21, 2003 interview. AR 270-71. In summarizing plaintiff's psychological testing results from March 25, 2003, Dr. Musholt noted that there was a split in the scores that indicated at least some possibility that plaintiff was feigning a mental disorder and exaggerating complaints and problems. AR 269.

Unable to conclude whether plaintiff was competent, Dr. Musholt recommended inpatient treatment at the Mendota Mental Health Institute on March 11, 2003. AR 272. Dr. Musholt noted that during the initial part of plaintiff's hospital stay, plaintiff responded appropriately to questions asked in a competency group, although he had been unable to answer questions posed during Dr. Musholt's earlier competency assessment interviews. Dr. Musholt believed that this discrepancy could either indicate feigning or simply reflect the less stressful environment of group. AR 270.

During plaintiff's stay at Mendota Mental Health Institute in 2003, it often was noted that when plaintiff was playing volleyball, his affect became brighter. AR 226, 244,

249-50. In May 2003, it was noted that plaintiff frequently exhibited manipulative behavior and that he might be malingering and exaggerating his symptoms and problems. AR 222-23. In a July 1, 2003 report to the court, Dr. Janice Munizza wrote that plaintiff was a poor historian and that he reported either vague or contradictory information in a few instances. For example, one report said plaintiff was discharged from the army because of his ankle injury and another said it was for having flat feet. AR 274. When plaintiff was admitted to Mendota, it was recommended that he undergo a malingering test. In the discharge summary from August 2003, Dr. Saini indicated that malingering had been ruled out. AR 209.

D. Hearing Testimony

At his October 26, 2004 hearing, plaintiff testified that he had not worked since January 1, 1999 and lived with his mother, who either did the household chores or hired help. AR 312. Plaintiff testified that he could drive only 20-25 minutes at one time before he had pain in his ankle. AR 314. Plaintiff also confirmed that the limitations identified by Dr. Hildebrand in July 2002 still represented his condition, with two exceptions. The total amount of time he could stand, sit or walk in an eight-hour day had lessened because his pain has increased in his leg, ankle and back. Plaintiff also testified that he needs more time during an eight-hour day for elevating his legs. AR 314-16. Plaintiff testified that he

is currently taking Venlafaxine (phonetic) for depression, Ibuprofen, and a sleeping pill. AR 317.

Dr. Allen Hauer testified as a neutral medical expert at the hearing on the severity of plaintiff's mental impairment. Dr. Hauer reviewed plaintiff's mental health diagnoses and applied listing of impairments 12.04, 12.08 and 12.09 for mental disorders. Plaintiff's attorney did not cross-examine Dr. Hauer. AR 318-22.

Richard Willette testified as a neutral vocational expert. Willette testified that plaintiff had worked as a janitor (exertional level heavy, unskilled) and factory laborer (heavy, semiskilled) and had no transferable skills. AR 322-23. The administrative law judge asked Willette to consider what jobs, if any, would fit within the limitations of sedentary work with a sit stand option and limited contact with the public. Willette testified that the following types and amounts of jobs existed in the state of Wisconsin: sedentary assembler (6,000); production inspector, checker and examiner (1,000); sedentary hand packager (150); and general office helper (6,000). In response to the administrative law judge's inquiry, Willette testified that those jobs corresponded to the definitions in the Dictionary of Occupational Titles. AR 323.

Plaintiff's attorney asked Willette to assume the following hypothetical: a person who is able to sit for only 30 minutes at a time, then must stand; stand for only 30 minutes at a time, then must sit; sit, stand or walk for a total of two hours in an eight-hour work day; needs daily unscheduled breaks of 15 minutes; after prolonged sitting, must elevate his legs

six inches; and in a sedentary job, must elevate his legs 50% of the time. Willette testified that such a person would not be able to perform any of the previously identified jobs because anything above and beyond two 15-minute breaks and a half-hour lunch would not be allowed. AR 324.

E. The Administrative Law Judge's Decision

In reaching his conclusion that plaintiff was not disabled, the administrative law judge performed the required five-step sequential analysis. See 20 C.F.R. §§ 404.1520, 416.920. The administrative law judge reserved ruling on step one because further evidence and evaluation were required. At step two, he found that plaintiff had the following severe, medically-determinable impairments: degenerative joint disease of the right ankle; some degenerative changes predominating at L2-3; affective disorders; personality disorders; and a history of drug or alcohol abuse or both in possible current remission. At step three, he found that plaintiff did not have an impairment or combination of impairments that met or medically equaled any impairment listed in 20 C.F.R. 404, Subpart P, Appendix 1, Regulation No. 4.

At step four, the administrative law judge assessed plaintiff's residual functional capacity, taking into account plaintiff's subjective complaints regarding his symptoms and limitations, as well as the various medical opinions in the record. The administrative law judge determined that plaintiff retained the residual functional capacity for unskilled

sedentary work with the following limitations: limited contact with the public or supervisors and the ability to change positions from sitting to standing as needed. In reaching his conclusion, the administrative law judge placed great weight on the opinion of the disability determination services medical consultants and little weight on Dr. Hildebrand's opinion regarding plaintiff's limitations. The administrative law judge also found that plaintiff's allegations regarding his limitations were not totally credible given the inaccurate and conflicting information he gave, reports of possible malingering and misrepresentation in the medical record, his sporadic work history before the alleged disability onset date, his significant gaps in seeking treatment, his failure to follow up on doctors' recommendations and his admission of certain abilities.

Relying on the testimony of the vocational expert, the administrative law judge found at step four that plaintiff lacked the residual functional capacity to perform his past relevant work. However, he found that the vocational expert's testimony was sufficient to satisfy the commissioner's burden at step five to show that other jobs existed in significant numbers that plaintiff could perform, namely, assembler, production inspector, hand packager, and office helper. AR 13-28.

OPINION

A. Standard of Review

The standard by which a federal court reviews a final decision by the commissioner is well settled: the commissioner's findings of fact are "conclusive" so long as they are supported by "substantial evidence." 42 U.S.C. § 405(g). Substantial evidence means "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Richardson v. Perales, 402 U.S. 389, 401 (1971). When reviewing the commissioner's findings under § 405(g), the court cannot reconsider facts, reweigh the evidence, decide questions of credibility, or otherwise substitute its own judgment for that of the administrative law judge regarding what the outcome should be. Clifford v. Apfel, 227 F.3d 863, 869 (7th Cir. 2000). Thus, where conflicting evidence allows reasonable minds to differ as to whether a claimant is disabled, the responsibility for that decision falls on the commissioner. Edwards v. Sullivan, 985 F.2d 334, 336 (7th Cir. 1993). Nevertheless, the court must conduct a "critical review of the evidence" before affirming the commissioner's decision, id., and the decision cannot stand if it lacks evidentiary support or "is so poorly articulated as to prevent meaningful review." Steele v. Barnhart, 290 F.3d 936, 940 (7th Cir. 2002). When the administrative law judge denies benefits, she must build a logical and accurate bridge from the evidence to his conclusion. Zurawski v. Halter, 245 F.3d 881, 887 (7th Cir. 2001).

Although the administrative law judge's written opinion need not evaluate every piece of testimony and evidence submitted, the administrative law judge must "sufficiently articulate his assessment of the evidence to assure" the court that he considered the

important evidence. Rohan v. Chater, 98 F.3d 966, 971 (7th Cir. 1996) (citing Carlson v. Shalala, 999 F.2d 180, 181 (7th Cir. 1993)). The administrative law judge's opinion must adequately articulate how the evidence was weighed so that this court may trace the path of the administrative law judge's reasoning. Id.

B. Analysis

1. Fibromyalgia and plaintiff's limitations

Plaintiff contends that the administrative law judge's decision is not supported by substantial evidence because he failed to consider evidence showing that plaintiff suffers from fibromyalgia and the impact of that condition on his residual functional capacity. Plaintiff cites his positive test for Lyme Disease, the fact that this disease was active for nine months before treatment began and the notes of Dr. Hildebrand as conclusive evidence of his fibromyalgia. Dkt. #12 at 39. Citing Sarchet v. Chater, 78 F.3d 305 (7th Cir. 1996), plaintiff argues that an administrative law judge is required to give "special consideration" in fibromyalgia cases and may not discredit "subjective symptoms" merely because of a lack of objectively discernible clinical findings. Plaintiff contends that the administrative law judge violated this rule by 1) discounting his treating physician's diagnosis of fibromyalgia because her opinion was based on plaintiff's subjective complaints and 2) rejecting plaintiff's

subjective complaints of disabling pain on the ground that they were not supported by the objective medical evidence.

As an initial matter, plaintiff did not claim fibromyalgia in his disability application or raise the condition during the initial or reconsideration determinations or at the hearing. Further, a review of the administrative record does not show that the administrative law judge rejected an entire line of relevant medical evidence without articulating his analysis. Herron v. Shalala, 19 F.3d 329, 333 (7th Cir. 1994) (citations omitted).

Plaintiff did not ever receive a definitive diagnosis of fibromyalgia or undergo any tests or treatment for fibromyalgia. Plaintiff first complained of generalized muscle and joint pain, cramping, low energy, and depression in July 2001, and the nurse practitioner expressed concern that plaintiff may have "a more systemic process occurring / possibly fibromyalgia." Plaintiff was referred to rheumatology for further evaluation. AR 196-98. A month later, Dr. Wicklund ordered a laboratory test for lyme titer. On November 7, 2001, Dr. Gowing ordered laboratory tests for plaintiff's musculoskeletal complaints. AR 162, 190. Plaintiff failed to undergo the ordered laboratory tests and did not seek treatment again until January 16, 2002, when Dr. Gowing explained that they still did not have a diagnosis for his musculoskeletal complaints and plaintiff would have to undergo the ordered tests. AR 162. On January 30, 2002, Dr. Gowing noted that plaintiff tested positive for Lyme Disease and that it had been active for nine months. Plaintiff apparently was told that he had Lyme Disease in the summer of 2001, but he did not receive treatment. Dr. Gowing

prescribed 100 mg Doxycycline twice daily for two months and noted that some of plaintiff's "symptoms may be related to fibromyalgia which is associated with Lyme Disease and may not respond to treatment with doxycycline." AR 159. Six months later, Dr. Hildebrand repeated Dr. Gowing's note that some of plaintiff's symptoms "may be related to fibromyalgia which is associated with Lyme disease (fatigue)." In response to a work ability questionnaire, Dr. Hildebrand listed plaintiff's diagnoses only as a history of Lyme disease and severe degenerative arthritis of the ankles and lumbar spine. AR 155-58.

Even accepting plaintiff's assertion that there is medical evidence of fibromyalgia, a review of the administrative law judge's decision and the administrative record shows that the administrative law judge considered all of the relevant evidence and did not ignore plaintiff's musculoskeletal complaints. He summarized both the July 2001 fibromyalgia reference by the nurse practitioner and Dr. Gowing's diagnosis and treatment of plaintiff's Lyme Disease. Although the administrative law judge did not specifically discuss Dr. Hildebrand's mention of possible fibromyalgia, his findings that plaintiff suffered from degenerative joint disease of the right ankle and degenerative changes in his spine are consistent with Dr. Hildebrand's diagnoses. Further, the administrative law judge specifically considered the various work limitations recommended by Dr. Hildebrand.

Plaintiff contends that the administrative law judge erred by not giving controlling weight to the assessment of Dr. Hildebrand and by failing to give "good reasons" for rejecting her report, which included responses to a residual functional capacity questionnaire.

SSR 96-2p and 20 C.F.R. § 404.1527 (administrative law judge must give good reasons for rejecting opinion of treating physician). I do not find this argument persuasive. As an initial matter, it is unclear whether the administrative law judge considered Dr. Hildebrand a treating source. However, he did note that plaintiff saw Dr. Hildebrand only once and for the sole purpose of generating evidence for his appeal. AR 17. 20 C.F.R. §§ 404.1502, 416.902 (not a treating source where no ongoing relationship or where relationship based solely on need to obtain report in support of claim for disability). Regardless, the administrative law judge provided good reasons for not adopting the residual functional capacity assessment of Dr. Hildebrand.

The administrative law judge determined that Dr. Hildebrand's opinions as to plaintiff's limitations were based on plaintiff's own assertions, which the administrative law judge found to be exaggerated and unsupported by other evidence of record. He also found that the plaintiff saw Dr. Hildebrand not in an attempt to seek treatment, but rather in an effort to generate evidence for his social security appeal. The administrative law judge also noted that it was not clear whether Dr. Hildebrand actually performed range of motion testing on plaintiff the day the form was completed. AR 17. Although he found some of Dr. Hildebrand's opinions regarding plaintiff's limitations to be "rather extreme," he did emphasize that certain aspects of Dr. Hildebrand's opinion were in fact consistent with his own residual functional capacity finding. AR 24.

It is true that the administrative law judge discounted some of the limitations reported by Dr. Hildebrand because they were based in large part on plaintiff's subjective complaints. However, it is well settled that an administrative law judge may properly disregard a medical opinion when it is premised on the claimant's self-reported symptoms and the administrative law judge has reasons to doubt the claimant's credibility. See, e.g., Diaz v. Chater, 55 F.3d 300, 307 (7th Cir. 1995) (administrative law judge could properly reject portion of physician's report that was based upon plaintiff's own statements of functional restrictions where administrative law judge properly found that plaintiff's subjective statements were not credible); Mastro v. Apfel, 270 F.3d 171, 177-78 (4th Cir. 2001) (affirming administrative law judge's disregard of treating physician's opinion because opinion "was based largely upon the claimant's self-reported symptoms" and was not supported by objective medical evidence); Morgan v. Commissioner of the Social Security Administration, 169 F.3d 595, 602 (9th Cir. 1999) (physician's opinion of disability premised to large extent upon claimant's own accounts of symptoms and limitations may be disregarded where those complaints have been properly discounted). Accordingly, if the administrative law judge properly discounted plaintiff's subjective statements, it follows that he could properly reject medical opinions to the extent they were based upon those statements.

An administrative law judge's credibility determination is given special deference because the administrative law judge is in the best position to see and hear the witness and

determine credibility. Shramek v. Apfel, 226 F.3d 809, 812 (7th Cir. 2000) (citation omitted). In general, an administrative law judge's credibility determination will be upheld unless it is "patently wrong." Prochaska v. Barnhart, 454 F.3d 731, 738 (7th Cir. 2006) (citation omitted); Sims v. Barnhart, 442 F.3d 536, 538 (7th Cir. 2006) ("Credibility determinations can rarely be disturbed by a reviewing court, lacking as it does the opportunity to observe the claimant testifying."). However, the administrative law judge still must build an accurate and logical bridge between the evidence and the result. Shramek, 226 F.3d at 811.

Without citing any specific reasons, plaintiff generally asserts that the administrative law judge's credibility determination did not comport with the requirements of Social Security Ruling 96-7p, which explains how administrative law judges are to evaluate the credibility of a claimant's subjective complaints. Brindisi v. Barnhart, 315 F.3d 783, 787 (7th Cir. 2003) (administrative law judges must comply with SSR 96-7p). See also 20 C.F.R. §§ 404.1529, 416.929. Plaintiff simply argues that the administrative law judge was required to accept his allegations concerning his symptoms and limitations because a "fibromyalgic condition" would support such allegations and account for a lack of supporting objective evidence. However, even in fibromyalgia cases, the administrative law judge is permitted to consider a discrepancy between the medical evidence and a plaintiff's subjective complaints as a factor tending to undermine the plaintiff's credibility. It just can't be the *only* factor. See, e.g., Powers v. Apfel, 207 F.3d 431, 435 (7th Cir. 2000) (upholding

administrative law judge's determination in fibromyalgia case that plaintiff's credibility was undermined by discrepancy between degree of pain claimed and that suggested by medical evidence).

Contrary to plaintiff's suggestion, the administrative law judge did not rely solely on the lack of supporting objective medical evidence as a basis for rejecting plaintiff's subjective complaints. The administrative law judge cited numerous reasons to support his finding that plaintiff's allegations regarding his limitations were not entirely credible.

For example, the administrative law judge noted several instances in which plaintiff provided inaccurate and conflicting information. Most notable was the fact that plaintiff testified that he had not worked since January 1, 1999, but plaintiff's Insured Status Report showed this was not true. See AR 69-70 (earnings reported in 2000, 2001, and 2005). In his disability report, plaintiff indicated that he completed twelfth grade, but he testified at his hearing that he received only an eleventh grade education. AR 85, 311. The administrative law judge also noted conflicting reports about plaintiff's discharge from the army, either because of the ankle injury or for having flat feet. AR 274, 312-13.

In addition, the administrative law judge noted that the medical records from several sources contained reports of possible malingering or exaggeration over the years. AR 18-20, 24. He also noted that plaintiff was playing volleyball during his hospitalization in 2003, an activity that was inconsistent with plaintiff's alleged limitations. The administrative law judge acknowledged that Dr. Saini stated in the Mendota discharge summary that

malingering had been ruled out, but the administrative law judge noted that a recommended malingering test had never been done. Further, there were reports from various sources of plaintiff feigning, conning or embellishing dating back as early as 1995.

The administrative law judge noted that plaintiff had worked only sporadically before his alleged disability onset date, raising the question whether his unemployment was actually caused by his medical impairments. In addition, he noted that plaintiff's disabling impairments were present at approximately the same level of severity prior to the alleged onset date, at a time when plaintiff was able to work. The administrative law judge wrote that plaintiff was able to take care of himself, drive and had not received the type of medical treatment (including prescribed medications) one would expect from a totally disabled individual. In support of this statement, he cited the significant gaps in plaintiff's treatment history and plaintiff's failure to follow up on doctors' recommendations. AR 23-24.

I have reviewed the record and find that each of the administrative law judge's findings well founded. Plaintiff has not challenged any of these findings. In conducting his credibility analysis, the administrative law judge considered not only the objective medical evidence but the other relevant SSR 96-7p factors, including plaintiff's daily activities, other treatment or measures taken to relieve his symptoms and work history. Further, even if the administrative law judge erred technically in failing to address the SSR 96-7p factors, that error was harmless.

Accordingly, plaintiff has not demonstrated that this is one of those rare occasions on which the court should disturb the administrative law judge's credibility finding. The administrative law judge built an accurate and logical bridge between the evidence and his conclusion that plaintiff's allegations of disabling symptoms were not fully credible. Further, because the record supports the administrative law judge's conclusion that Dr. Hildebrand's restrictive opinion of plaintiff's abilities was based largely on plaintiff's subjective complaints, the administrative law judge properly determined that Dr. Hildebrand's opinion was entitled to little weight.

2. Step five determination

Plaintiff contends that the administrative law judge failed to comply with his mandatory duty under SSR 00-4p regarding vocational expert testimony about the requirements of a job or occupation. SSR 00-4p requires the administrative law judge to ask the vocational expert about any possible conflicts between his testimony and the Dictionary of Occupational Titles and to elicit reasonable explanation for any discrepancy. See Prochaska, 454 F.3d at 735. Plaintiff agrees that the administrative law judge satisfied the first part of the ruling's requirements by asking the vocational expert whether his testimony was consistent with the information contained in the Dictionary of Occupational Titles. However, the vocational expert never stated at the hearing that his testimony was in conflict with the dictionary. Plaintiff argues that the administrative law judge did not meet the

second prong because he failed to elicit an explanation why the job requirements identified by the vocational expert were not consistent with the Dictionary of Occupational Titles.

It was only after the hearing that plaintiff identified a conflict between the vocational expert's testimony and the Dictionary of Occupational Titles. Plaintiff's attorney did not cross-examine the vocational expert on this issue, did not ask him to explain the job requirements in more detail and did not ask the administrative law judge to keep the record open so that he could cross-check the jobs identified by the vocational expert with the Dictionary of Occupational Titles. Plaintiff apparently believes that reversal is warranted any time a plaintiff identifies a potential conflict with the Dictionary of Occupational Titles, even if the administrative law judge complied with his duty to question the vocational expert under SSR 00-4p and plaintiff does not identify a conflict until after the hearing.

At the hearing, the administrative law judge asked the vocational expert whether the job requirements that he identified were consistent with the Dictionary of Occupational Titles, and the vocational expert responded yes. AR 323. Hearing the vocational expert's affirmative response, the administrative law judge had no obligation under SSR 00-4p to inquire further. Prochaska, 454 F.3d at 735 ("*If* the VE's or VS's evidence appears to conflict with the Dictionary of Occupational Titles, the adjudicator will obtain a reasonable explanation for the apparent conflict." (emphasis added)). The administrative law judge was entitled to conclude from the vocational expert's qualifications and his testimony that the vocational expert's testimony was reliable. Donahue v. Barnhart, 279 F.3d 441, 446 (7th

Cir. 2002) ("an expert is fee to give a bottom line, provided that the underlying data and reasoning are available on demand"). Neither Prochaska nor SSR 00-4p lend any support to plaintiff's suggestion that more was required.

ORDER

IT IS ORDERED that the decision of the Commissioner of Social Security is AFFIRMED and plaintiff Allen Stark's appeal is DISMISSED.

The clerk of court is directed to enter judgment for defendant on plaintiff's claim and close this case.

Entered this 28th day of March, 2007.

BY THE COURT:

/s/

BARBARA B. CRABB
District Judge