IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF WISCONSIN

EVELYN M. KLAWES,

Plaintiff,

v. MEMORANDUM AND ORDER

JO ANNE BARNHARDT, Commissioner of Social Security, 06-C-352-S

Defendant.

Plaintiff Evelyn M. Klawes brings this action pursuant to 42 U.S.C. § 405(g) for review of the defendant Commissioner's final decision denying her Disability Insurance Benefits (DIB) and Supplemental Security Income (SSI). She asks the Court to reverse the decision or in the alternative to remand for further proceedings.

Plaintiff applied for benefits on November 28, 2003 alleging disability as of June 1, 1999 due to a bad left knee and black out spells. Her application was denied initially and upon reconsideration. A hearing was held on December 6, 2005 before Administrative Law Judge (ALJ) John H. Pleuss. In a written decision dated March 13, 2006 the ALJ found plaintiff not disabled. The ALJ's decision became the final decision of the Commissioner when the Appeals Council denied plaintiff's request for review on May 23, 2006.

FACTS

Plaintiff Evelyn M. Klawes was born on September 22, 1954. She completed the sixth grade and training as a diesel truck driver. Her past relevant work experience were jobs as dump truck and over-the-road driver, cashier and assembler.

Plaintiff had knee replacement surgery in Tennessee in January 2003. In September 2003 plaintiff was seen by Dr. McMurray for knee pain. An examination and x-rays indicated that she had a successful undamaged knee arthroplasty.

In December 2003 plaintiff's daughter reported that plaintiff had seizures twice a month causing her to pass out and shake which lasted for thirty minutes to two hours. She also reported plaintiff had five "staring spells" or episodes of an inability to talk per week.

In January 2003 plaintiff was seen for an acute onset of disorientation. She was admitted for a neurological workup. Her head MRI was unremarkable. EEG studies suggested abnormalities commonly seen with migraines. Plaintiff was discharged with a diagnosis of a complex migraine.

Plaintiff was treated for severe headaches for two years by neurologist, Douglas Dulli, M.D. Dr. Dulli indicated that plaintiff had frequent refractive headaches with syncope which causes vertigo, mental confusion, nausea and mood changes. Dr. Dulli indicated that plaintiff had blackout symptoms as a result of

migraine headaches but they were not seizure-based. Dr. Dulli found that plaintiff is required to lie down two hours in an eight hour work-day and cannot handle even low stress jobs.

In February 2004 William Merrick, Ph.D., performed a psychological examination of plaintiff to evaluate her depression and memory problems at the request of the Social Security Administration. Dr. Merrick questioned the veracity of plaintiff's representation but found that plaintiff's mental functioning would make her unable to consistently understand, remember and carry out instructions or maintain compensation or work pace. He also concluded she would have severe problems withstanding routine work stresses or adapting to changes.

In August 2004 Dr. Dar Muceno, a state agency physician, reviewed the medical evidence and concluded that plaintiff could lift 20 pounds occasionally and ten pounds frequently, could sit stand and walk for six hours and avoid concentrated exposure to hazards. Dr. Latchamsetty, a state agency physician, agreed with this assessment.

In March 2004 Dr. Rattan, a state agency psychologist, reviewed the evidence and concluded plaintiff did not have a medically determinable mental impairment. On August 11, 2004 Dr. Matkom, a state agency psychologist, reviewed the evidence and concluded plaintiff had an affective disorder with moderate limitation in daily activities, mild limitation in social

functioning, concentration, persistence or pace and no episodes of decompensation. Dr. Kovar, a consulting psychologist, agreed with this assessment.

In October 2004 plaintiff was seen for general shaking and headaches. Her EEG was normal. Dr. Bellazini assessed plaintiff and concluded she had a "purely non-organic illness." Plaintiff declined a psychiatric consultation.

On November 5, 2004, plaintiff was seen by Dr. Eichelman for a psychiatry consultation. A battery of diagnostic testing was normal. Dr. Eichelman concluded plaintiff did not have a somotaform disorder because she did not manifest enough physical symptoms to meet the criteria. Dr. Eichelman found that plaintiff does not really endorse symptoms suggestive of significant depression at the present time. He assigned a GAF score of 55-60 indicating moderate symptoms.

Plaintiff saw Dr. Rod H. Peterson, a psychiatrist, in the fall of 2004 but had been seen by his department in June 2004. As of November 5, 2004 plaintiff was taking the following medications: Ssulfasalazine, Fluoexetine, Pantoprazole, Gabapentin, Divalproic, Atenolol and Nitrofurantoin.

In March 2005 Dr. Peterson completed a form stating that as of June 30, 2004 and ongoing plaintiff had fair ability to remember work-like procedures, understand and remember very short and simple instructions and carry out very short and simple instructions. He

also concluded that she could not complete a normal workday and work week without interruptions from psychologically based symptoms. He further found that plaintiff could not deal with the stress of semi-skilled and unskilled work. Dr. Peterson diagnosed Plaintiff with mood disorder, anxiety disorder, somatization disorder and chronic pain disorder.

In December 2004 plaintiff went to the emergency room twice complaining of migraine and shaking episodes. EKG's and head scans were normal. After a psychiatric consultation plaintiff was assessed with a conversion reaction and psychotherapy was recommended.

At the December 6, 2006 hearing before the ALJ plaintiff appeared with her attorney and testified that she had constant daily headaches. She also testified that for two years she had blackouts. Plaintiff's husband testified that plaintiff had blackout spells which involved staring and shaking.

Leslie Goldsmith, a vocational expert, testified at the hearing. The ALJ asked her what jobs were available for an individual with plaintiff's age, education and experience who retained the residual functional capacity to perform sedentary work not requiring lifting any more than ten pounds, no standing for more than thirty minutes at a time, no more than occasional stooping, ending or crouching and no climbing, crawling or kneeling, no work around unprotected heights or dangerous

machinery, a limited but satisfactory ability to interact with supervisors, deal with work stresses, and maintain attention and concentration, and a seriously limited ability to understand, remember and carry out detailed instructions. The expert testified that such a person could perform plaintiff's past work as an assembler together with thousands of other available jobs.

In his written decision the ALJ concluded that plaintiff had severe impairments of a history of total knee replacement surgery and complaints of syncope and migraine headaches but that she did not have a severe mental impairment. He found that plaintiff's statements concerning the intensity, duration and limiting effects of these symptoms are not entirely credible. The ALJ discounted the opinion of Dr. Dulli that plaintiff was severely disabled by headaches and syncope stating it was of little weight because, "the headaches and syncope were felt to be factitious by the majority of treating sources, including Dr. Dulli's own associates."

The AlJ found that plaintiff retained the residual functional capacity to perform sedentary work not requiring lifting any more than ten pounds, no standing for more than thirty minutes at a time, no more than occasional stooping, ending or crouching and no climbing, crawling or kneeling and no work around unprotected heights or dangerous machinery. The ALJ also found plaintiff has a limited but satisfactory ability to interact with supervisors, deal with work stresses, and maintain attention and concentration

but has a seriously limited ability to understand, remember and carry out detailed instructions. He concluded that plaintiff was not disabled because she could perform her past relevant work as an assembler.

The ALJ made the following findings:

> 1. The claimant meets the insured status requirements of the Social Security Act through December 31, 2004.
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> 2. The claimant has not engaged in substantial gainful activity at any time relevant to this decision (20 CFR 404.1520(b)).
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> 3. The claimant has the following severe impairments: a history of total knee replacement surgery in January 2003 and complaints of syncope and constant migraine headaches with no discernible abnormalities on neurological evaluation, CT scan, EEGs or other clinical testing (See: Exhibits B2F and B11F)(20 CFR 404.1520(c)).
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> 4. The claimant does not have an impairment or combination of impairments that meets or medically equals one of the listed impairments in 20 CFR Part 404, Subpart P Appendix 1 (20 CFR 404.1520(d), 404.1525 and 404.1526).
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> 5. After careful consideration of the entire record, I find that the claimant has the residual functional capacity to perform sedentary work not requiring that she lift any more than ten pounds. She is precluded form more than occasional stooping, bending or crouching and cannot perform any climbing, crawling or kneeling. She can stand for up to thirty minutes at a time. She has a limited but satisfactory ability to interact with supervisors, deal with work stresses, and maintain attention and concentration. She is seriously limited but not precluded from work requiring that she understand, remember and carry out detailed instructions. Moreover, she

should not work around unprotected heights or dangerous machinery.

6. The claimant is capable of performing her past relevant work as an assembler. This work does not require the performance of work-related activities precluded by the claimant's residual functional capacity (20 CFR 404.1565).

7. The claimant has not been under a "disability," as defined in the Social Security Act from September 9, 19999 through the date of this decision (20 CFR 404.1520(f).

OPINION

This Court must determine whether the decision of the Commissioner that plaintiff was not disabled is based on substantial evidence pursuant to 42 U.S.C. § 405(g). See Arbogast v. Bowen, 860 F. 2d 1400, 1402-1403 (7th Cir. 1988). Substantial evidence is defined as "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Richardson v. Perales, 402 U.S. 389, 401 (1971).

Disability determinations are made pursuant to a five-step sequential evaluation procedure. 20 CFR § 404.1520(a)-(f). First, the claimant must not be performing substantial gainful activity. Second, the claimant must have a severe, medically determinable impairment. Third, a claimant will be found disabled if his or her impairment is equal in severity to a listed impairment in 20 C.F.R. Subpart P, Appendix 1. Fourth, if the claimant does not meet the third test, he/she must not be able to perform his/her past work. Fifth, if the claimant cannot perform his/her past work, he or she

must not be able to perform any existing jobs available in the national economy given his or her educational background, vocational history and residual functional capacity.

The ALJ found that plaintiff had severe impairments of knee replacement surgery, complaints of syncope and constant migraine headaches. The ALJ further found that plaintiff retained the residual functional capacity to perform sedentary work not requiring lifting any more than ten pounds, no standing for more than thirty minutes at a time, no more than occasional stooping, ending or crouching and no climbing, crawling or kneeling and no work around unprotected heights or dangerous machinery. The ALJ also found plaintiff had a limited but satisfactory ability to interact with supervisors, deal with work stresses, and maintain attention and concentration, was seriously limited but not precluded from work requiring that she understand, remember and carry out detailed instructions. He concluded that she was not disabled because she could perform her past work as an assembler.

Plaintiff argues that the ALJ improperly found that plaintiff had no mental impairment. There is conflicting evidence in the record concerning plaintiff's possible mental impairment. Dr. Eichelman stated that plaintiff was not depressed nor did she have a somotaform disorder in November 2004, but also in the fall of 2004 Dr. Peterson diagnosed plaintiff with an affective disorder which severely affected her ability to work. Dr. Rattan who evaluated

plaintiff for the Social Security Administration found plaintiff had no mental impairment but Dr. Matkokm who also evaluated plaintiff for the Social Security Administration, found plaintiff had an affective disorder. Dr. Kovar, a consulting psychologist, also agreed with Dr. Matkom.

In December 2004 treating doctors at the emergency room referred plaintiff for psychological evaluation and therapy. There is not substantial evidence in the record to support the ALJ's conclusion that plaintiff did not have a mental impairment. The Court will remand the case to the Commissioner to determine whether or not plaintiff had a severe mental impairment and if so consider its effect on her residual functional capacity.

Plaintiff argues that the ALJ improperly considered plaintiff's credibility pursuant to SSR 96-7 p which requires an analysis of daily activities, symptom intensity and duration, precipitating factors, medication, treatment other than medication and the resulting functional limitations. The ALJ did not address plaintiff's medications, daily activities or the observations of her family members in assessing her credibility.

The Court cannot affirm the ALJ's credibility determination. On remand the ALJ should consider plaintiff's medications, daily activities and the observations of her family members in determining plaintiff's credibility concerning her subjective complaints.

Plaintiff argues that the ALJ failed to give the proper weight to the opinion of plaintiff's treating neurologist, Dr. Dulli, concerning her headaches and blackouts. The opinion of Dr. Dulli, plaintiff's treating physician, is to be given controlling weight if it is well-supported by medically accepted clinical and laboratory diagnostic techniques and not inconsistent with the other substantial evidence in the record. See 20 C.F.R. §§ 404.1527(d)(2), 416.927(d)(2); SSR 96-2p.

The ALJ gave Dr. Dulli's opinion little weight because "the headaches and syncope were felt to be factitious by the majority of treating sources, including Dr. Dulli's own associates." This comment with no cites to the record is conclusory and vague. On remand the ALJ should also reconsider the weight to be give Dr. Dulli's opinion that plaintiff could not work because of her headaches and blackouts.

This case will be remanded to the Commissioner for those further proceedings as aforesaid.

ORDER

IT IS ORDERED that the above entitled matter is REMANDED to the Commissioner for further proceedings consistent with this opinion.

Entered this 24th day of November, 2006.

BY THE COURT:

____s/_____
JOHN C. SHABAZ
District Judge