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

TAMMY JOHNSON,

Plaintiff,

v.

CAROLYN W. COLVIN, Acting Commissioner of Social Security,

Defendant.

OPINION AND ORDER

15-cv-294-wmc

Pursuant to 42 U.S.C. § 405(g), plaintiff Tammy Johnson seeks judicial review of a final denial of her application for Social Security Disability Insurance Benefits and Supplemental Security Income on the grounds that the ALJ erred: (1) by ignoring the retrospective opinion of Dr. Harry Fernandes; and (2) by finding that Johnson's migraine headaches were not a severe impairment. The court heard oral argument on plaintiff's related contentions on September 8, 2016. For the reasons provided below, the court will now affirm the Commissioner's denial of plaintiff's application.

FACTS

A. Background

Johnson was 43 years old at the time she applied for SSI on July 24, 2011, but only 37 at the alleged onset date, April 1, 2006. She was last insured on September 30, 2009.

Johnson has at least a tenth-grade high school education, is able to communicate in English, and has past work experience as a cashier and personal aide at a residential home for mentally impaired individuals. Johnson testified at her hearing that she last

worked in 2006. She claims disability based on anxiety and migraines, though the focus of her appeal is on the latter.

B. Relevant Medical Records

For the relevant period of time, from 2006 to 2009, the medical records are extremely limited. One week before her claimed onset date, March 20, 2006, Dr. Ellen L. Parris (a neurologist) noted that the drug Paxil has worked out over other medications for controlling anxiety; that Johnson was experiencing headaches four days a week, but "deals with them and doesn't miss work because of them; and that she "enjoy[s] her current job as a bookkeeper." (AR 228-30.)

Some seven months later, on October 18, 2007, Dr. Parris noted that Johnson reported headaches several times per week, which were especially bad around her menstrual cycle, but that she was mostly "dealing with" the headaches, despite missing work 1-2 days per week. Parris also noted that Johnson was treating her headaches with Tylenol and ice, and that her anxiety is "wonderfully controlled" with Paxil. Johnson's physical examination was also normal. Finally, the notes from October of 2007 indicate that Johnson was going to try a new medication (Amerge) for headaches. (AR 224-25.)

Another nine and a half months then pass before Parris's office noted a call from Johnson on August 4, 2008, inquiring whether she could continue take Paxil now that she was pregnant. (AR 222.) Some ten additional months then pass until a May 22, 2009, note indicates that Johnson was told that she needed to be seen for an appointment or there would be no further medication refills. (AR 219.) Nevertheless, a

July 16, 2009, note reported that Johnson failed to show up for a neurology appointment.

Some three years later, Dr. Harry Fernandes, Johnson's primary care physician, completed a residual functional capacity questionnaire on August 3, 2012, which states that he had been treating Johnson since 2009, for chronic migraine headaches and anxiety disorder. (AR 278-81.) In the questionnaire, Dr. Fernandes noted that Johnson experienced severe headaches 2 to 3 times per week, accompanied by visual disturbances, photosensitivity, nausea / vomiting, mood changes, and intolerance to noise. He also noted that Johnson was diagnosed with migraines at the age of 17, but that they are "getting worse now." (AR 278.) As an "objective sign" of her headaches, Dr. Fernandes noted that Johnson found it "difficult to concentrate and function." (AR 279.) Fernandes also indicated that she could not generally work an 8 hour day without lying down, stating that "about 3 days a week, when [her] headaches [are] severe, she needs to lie down for 4-5 hours." (AR 280.) Finally, Fernandes noted that 2007 was the "earliest date the above description of your patient's condition applies." (AR 281.)

In contrast to the limited records in terms of treatment during the relevant period of time from 2006 to 2009, Johnson's medical records from 2011 to 2013 reflect increased frequency and intensity of headaches, as well as increased efforts to try other medications for treatment. (AR 259-329.) In particular, treating physicians noted in 2012 and 2013 that Johnson's headaches had worsened in the past one to two years. (*See, e.g.*, AR 297 (9/5/12 note from Jeanne L. Pallagi M.D., a neurologist, stating that Johnson reported daily headaches in the "past 1-2 years"); AR 324-36 (5/17/13 note from

Daniel S. Sa M.D., a neurologist, stating that Johnson reported headaches that have "worsened recently, particularly over the past year").)

C. ALJ Decision

The ALJ held an evidentiary hearing on September 18, 2013, at which Johnson and a vocational expert testified. In his written opinion dated October 8, 2013, the ALJ determined that Johnson "did not have an impairment or combination of impairments that significantly limited the ability to perform basic work-related activities for 12 consecutive months; therefore, the claimant did not have a severe impairment or combination of impairments." (AR 18.) In making that determination, the ALJ noted a lack of evidence of 12 consecutive months of impairment during the relevant period of time, relying on: (1) a March 20, 2006, doctor's note, a little over a week before the alleged onset date, that Johnson was not missing work due to headaches, was enjoying her job and reported her anxiety was well-controlled with Paxil; (2) an October 2007 note, describing plans to take a new medication to address menstrual headaches; (3) Johnson's pregnancy in 2008 and 2009, during which Johnson reported that her headaches were better; and (4) medical records showing no additional appointments before Johnson's last insured date in September 2009. (AR 19-20.) Finally, the ALJ gave weight to the state agency consultant who opined that through the date last insured, Johnson did not have a severe impairment. (AR 20.)

With respect to Dr. Fernandes (who the ALJ referred to not by name but by his August 2012 report), the ALJ stated that he gave little weight to his opinions because: (1) Fernandes only started treating the claimant in August 2009, and therefore would not

be in a position to opine on her condition in 2007; (2) there was no medical evidence to support his finding that she would miss two to three days per week of work, especially in light of Johnson's statement in March 2006 that she was enjoying and not missing work; and (3) Johnson's own report in October 2007 that she was missing one to two days per month, coupled with the fact that she was given a new medication at that time and did not follow-up before the last insured date in September 2009. (AR 20.)

Finally, the ALJ indicated that there was "no objective medical evidence to support the allegation that [Johnson's] impairments caused more than minimal limitations on her ability to perform basic work-related activities during the period at issue." (AR 21.)

OPINION

Unlike a more typical social security appeal, the ALJ here did not find a severe impairment -- and thus, his analysis stopped at step 2. While perhaps Johnson's migraines would constitute a severe impairment now (and even at some earlier time, albeit *after* her last insured date of September 30, 2009), the ALJ determined that Johnson failed to establish a medical impairment or combination of impairments that lasted or can be expected to last for a continuous period of at least twelve months beginning during the time period between April 2006 (the alleged onset date) and September 2009 (the date last insured). *See Eichstadt v. Astrue*, 534 F.3d 663, 666 (7th Cir. 2008) (affirming denial of benefits in part because "the evidence post-dating [claimant's] date last insured. . . failed to support [claimant's] claim. Although this evidence tended to suggest that [claimant] is currently disabled, and perhaps was

disabled during the late 1990s, it provided no support for the proposition that she was disabled at any time prior to December 31, 1987").[1] Johnson argues that there are nevertheless two related bases for remand, which the court addresses in turn.

I. Consideration of Dr. Fernandes's Report

First, Johnson argues that the ALJ erred by "completely ignor[ing] the medical opinion of treating source, Dr. Harry Fernandes." (Pl.'s Br. (dkt. #10) 7.) While, as noted above, the ALJ did not mention his name, he certainly referred to Fernandes' report and explained why he was discounting its relevance for purposes of determining whether Johnson suffered a severe impairment during the relevant period of time from April 2006 to September 2009.

There are at least two core problems with Johnson's argument to the contrary. First, in responding "2007," to the question "[w]hat is the earliest date the above description of your patient's condition applies," Dr. Fernandes was not necessarily opining that Johnson was experiencing headaches requiring her to miss two to three days per week from 2006 through 2009. Second, and related, the ALJ could reasonably find fault with Fernandes if he was making such a determination of Johnson's limitations in 2007, since that dated back some five years before his 2012 RFC report and two years before he began to treat Johnson.

[1] The requirement that a claimant be disabled before the date last insured is specific to disability benefits. Perhaps Johnson would be eligible for supplemental security income. *See Liskowitz v. Astrue*, 559 F.3d 736, 739–40 & n. 2 (7th Cir. 2009) (explaining that a claimant for disability insurance benefits must show that she was disabled while she was insured whereas insured status is not required for a claim for supplemental security income).

As part of his challenge to the ALJ's treatment of Dr. Fernandes' report -- although seemingly unrelated -- Johnson also takes issue with the ALJ's consideration of her "sporadic treatment," arguing that the ALJ was required to explore this with the claimant. (PL.'s Br. (dkt. #10) 11.) The ALJ, however, did not generally rely on her lack of treatment in finding that she was not severely impaired. The lone exception was the ALJ's noting that Johnson was trying a new medication in October 2007 and told to return if it did not work, which she did not do. Notably, Johnson does not even argue that there was legitimate reason for her not seeking follow up treatment or complying with treatments (e.g., financial reasons, lack of insurance). More importantly, as the government points out, Johnson's insurance was not cut off until 2013 -- when she wanted to try Botox as a treatment option -- some four year after her last insured date.

II. Finding No Severe Impairment

Johnson's second argument is even more meandering. As far as the court can tell, the crux of the argument is that the ALJ erred in giving little weight to Johnson's report of symptoms. Here, too, the court encounters -- as did the ALJ -- the same timing issue. Even crediting Johnson's self-report at the time of the 2013 hearing about the frequency and severity of her headaches and the resulting limitations, that testimony does not necessarily reflect her condition during the relevant time period. Indeed, she testified that at least for the nine-month period when she was pregnant in 2008 and 2009, her headaches were well-controlled. Moreover, the contemporaneous medical records during that period do not reflect the limitations she described during the hearing. At most, she reported not being able to work one to two days per month.

During the hearing before this court, counsel for Johnson developed an argument not briefed, asserting that plaintiff confronts a relatively low burden to prove a severe impairment. Citing to the Seventh Circuit's recent opinion in *O'Connor-Spinner v. Colvin*, 832 F.3d 690 (7th Cir. 2016), counsel specifically argues that that Johnson's headaches pass step 2, which requires nothing more than "'a *de minimis* screening for groundless claims' intended to exclude slight abnormalities that only minimally impact a claimant's basic activities." *Id*. at 697 (quoting *Thomas v. Colvin*, 826 F.3d 953, 960 (7th Cir. 2016)).

As acknowledged above, step 2 *is* typically satisfied in the appeals to this court. Still, this case is among the seemingly narrow set of cases where the claimant has failed to present evidence to establish an impairment (or combination of impairments) that lasted or can be expected to last for a continuous period of at least twelve months beginning during the relevant time period. In *O'Connor-Spinner II*, the Seventh Circuit faulted the ALJ for ignoring contemporaneous medical records describing the claimant as suffering from "major depression, recurrent severe," and instead relying on state agency psychologists who did not examine the claimant. *Id.* at 698. The facts at issue in this case are distinguishable.

At the hearing before this court, counsel for Johnson conceded that her testimony alone could not establish a severe impairment, but argued that a state agency physician's July 2012 RFC -- stating that "Clmt's HAs were severe and limit[ing] her to avoiding concentrated exposure to heights and hazards during the Title II period" -- could provide such support. (AR 87.) Even if this statement were deemed to be an opinion that plaintiff suffered a severe impairment, rather than an assessment of Johnson's capacity to

engage in work, the state agency physician simply relied on and summarized the same medical record from 2006 to 2009 described above. Critically, that medical record does not provide a basis for finding a severe limitation, nor do Johnson's contemporaneously reported statements to her treating physicians at the time. Indeed, the state agency's physician only limited Johnson to the avoidance of heights and hazards.

Regardless, the court finds no error in the ALJ rejecting any opinion of a non-examining, non-treating state agency physician in the face of contemporaneous medical records that fail to demonstrate Johnson suffered from a severe impairment from April 2006 through September 2009.

ORDER

Accordingly, IT IS ORDERED that the decision of the Commissioner of Social Security, denying plaintiff Tammy Johnsons' application for disability benefits, is AFFIRMED. The clerk of court is directed to enter judgment for defendant and close this case.

Entered this 20th day of December, 2016.

BY THE COURT:

/s/

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WILLIAM M. CONLEY
District Judge