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

MICHAEL PERKINS,

Plaintiff,

REPORT AND
RECOMMENDATION

v.

01-C-003-C

LARRY G. MASSANARI,
Acting Commissioner of Social Security,

Defendant.

REPORT

Plaintiff Michael Perkins brings this action pursuant to 42 U.S.C. § 405(g) to review the final decision of the Commissioner of Social Security denying Perkins's claim for Disability Insurance Benefits under the Social Security Act. The Administrative Law Judge ("ALJ") found that Perkins was not disabled. The Appeals Council denied Perkins's request for review, thereby making the ALJ's decision the final decision of the Commissioner.

This matter comes before the court on plaintiff's motion for summary judgment seeking reversal of the Commissioner's decision. Plaintiff asks this court to award him benefits, or in the alternative, to remand this case to the Commissioner for further proceedings, on the ground that the ALJ improperly rejected the opinions of his treating physicians who concluded that he was disabled.

For the reasons set forth below, I recommend that this court reverse the decision of the Commissioner and remand it for further evaluation of the evidence. Although the ALJ's decision is generally well-supported by the record (and might remain unchanged following remand), the ALJ failed to discuss in his decision important evidence supporting both the plaintiff's claim and the opinion of his treating psychologist, Dr. Sweet.

The following facts are drawn from the administrative record:

Facts

I. Procedural Background

Plaintiff applied for a period of disability and disability insurance benefits on October 11, 1996. Plaintiff alleged that he had been disabled since December 1, 1995, as a result of symptoms from Post-Traumatic Stress Disorder ("PTSD"), including depression, flashbacks, sleep problems and isolation causing many absences from work. After the Social Security Administration denied his application initially and on reconsideration, plaintiff requested a hearing before an administrative law judge. An administrative hearing was held on June 4, 1998, at which plaintiff and a vocational expert testified. Plaintiff was represented by a lawyer at the hearing. On March 8, 1999, the ALJ issued a hearing decision denying plaintiff's claim on the ground that there were a significant number of jobs in the regional economy that plaintiff could perform despite his limitations. Thereafter, the Appeals

Council denied plaintiff's request for review, making the ALJ's decision the final decision of the Commissioner for purposes of judicial review.

II. Plaintiff's Background and Testimony

Plaintiff was born on February 11, 1945, making him 50 years old as of his alleged onset of disability and 54 years old on the date of the Commissioner's final decision. He has a high school education and past relevant work experience as a truck driver and a job service specialist for the State of Wisconsin. He is a Vietnam combat veteran. At the time of the administrative hearing, plaintiff was receiving disability retirement benefits from the State of Wisconsin and the Veterans Administration on the basis of his diagnosed post-traumatic stress disorder related to his war experiences. Plaintiff last worked on December 1, 1995.

At the administrative hearing, plaintiff testified that he was unable to work as a result of chronic PTSD. According to plaintiff, the onset of his PTSD symptoms began in 1993 when he came upon a car accident and pulled two dead people from a burning car. He testified that as part of his PTSD, he experiences severe anxiety attacks at least twice a month and minor anxiety attacks a couple times a week. Plaintiff testified that during a severe anxiety attack, he has to leave the situation and isolate himself, which would include leaving the workplace if he was at work. He testified that during a minor anxiety attack, he would have to momentarily leave the situation but he would not need to leave the workplace. He also testified that he experiences frequent nightmares, insomnia, flashbacks and

"regression" periods during which he shuts himself in his bedroom for three days at a time. Plaintiff testified that he has two "good days" a week during which he is comfortable enough to leave the house.

III. Medical Evidence

Plaintiff began counseling with Tom Deits at the Veterans Center in Madison in March 1995. Plaintiff reported a recent pattern of leaving his house and going to a hotel to "shut out the world." According to plaintiff, this recurrent behavior was causing problems at home and at work. Plaintiff reported that during these periods of isolation, he typically consumed alcohol but not always. Plaintiff reported having a long history of alcohol abuse. He indicated that he did not want to have PTSD although he did want an increase in his disability. Deits described plaintiff as the "type of veteran that anyone would want to assist & type of veteran who could be very skilled at maintaining what he wants because he's verbal, understand systems, has mitigating circumstances, etc." AR 284.

In May 1995, plaintiff was admitted to the Veterans Administration Medical Center in Tomah, Wisconsin, for alcohol dependence. Plaintiff did well in the program and was released on June 22, 1995. During his treatment, he was evaluated for post-traumatic stress disorder and accepted to participate in a PTSD program in January 1996. AR 238-255.

In September 1995, Deits reported that plaintiff had not followed through with his aftercare group treatment at the Veterans Hospital. On September 25, 1995, plaintiff's wife

called Deits and requested a couples session, stating that plaintiff had been at a hotel for three days. At the session, plaintiff denied that alcohol was the major problem, preferring to attribute his problems to PTSD and his delayed reaction to his Vietnam experience. Deits opined that plaintiff should receive inpatient treatment at the Veterans Hospital for PTSD. Plaintiff agreed to meet with Deits for counseling on a weekly basis.

On October 20, 1995, Deits reported that plaintiff was unable to see the depth of his alcohol problem but continued to focus on PTSD as the main problem. Plaintiff had been diagnosed with PTSD and was seeking additional veterans benefits. Deits noted that plaintiff did not seem to realize that his attempts to maximize his disability benefits was interfering with his family and his job. AR 272.

On December 4, 1995, plaintiff was again admitted to the veteran's hospital for detoxification and depression. Plaintiff reported being depressed on and off for several years. A mental status examination was normal, but noted that plaintiff reported combat dreams, hyperirritability to loud noises and flashbacks. Plaintiff was eventually transferred to the post-traumatic stress program, where he did well until his release on March 7, 1996. He was noted to be a good patient who was cooperative, got along well with his peers and was pleasant to deal with. AR 193. The notes from his final individual therapy session indicated that plaintiff planned to return to work after a period of convalescent time. AR 195.

On March 14, 1996, plaintiff's family doctor, Dr. Mark Bishop, completed a continuance of disability form on which he indicated that plaintiff was totally disabled as

a result of PTSD and related symptoms. However, Dr. Bishop opined that he expected plaintiff to be able to return to work in one to three months. AR 369.

Plaintiff saw Deits on May 9, 1996. Plaintiff indicated that he was seeking disability retirement from his job plus a substantial veterans disability benefit. Deits reported that plaintiff's expectation "is that I will support his claim and or provide follow-up & aftercare from Tomah. This session he discussed how to's of State and how to's of VA disability. His goal is security from system then start his own small employment service. Seems to be less depressed & active in helping himself & family." AR 268.

On April 18, 1996, Dr. Bishop completed a statement of disability in connection with plaintiff's application for long-term disability benefits from the State of Wisconsin. Dr. Bishop indicated that plaintiff was unable to engage in any substantial gainful activity as a result of PTSD and depression. Another physician, Dr. Frederick Coleman, indicated that plaintiff suffered from major depression and from PTSD with symptoms of anxiety, flashbacks, nightmares and withdrawal. On August 21, 1996, plaintiff was awarded long-term disability benefits. AR 260-64.

On September 13, 1996, the Veterans Administration determined that plaintiff's PTSD was 100 percent disabling on the basis of plaintiff's inability to work. The Veterans Administration noted that plaintiff's last employer reported that his performance had been poor and that he had frequent absences from work; that the state had found him eligible for long-term disability benefits; and that plaintiff continued to suffer from symptoms of PTSD.

The Veterans Administration indicated it would schedule an examination in the future to determine if plaintiff's PTSD continued to be so severe as to prevent him from engaging in productive employment. AR 257-59.

On October 1, 1996, Deits reported that he had not seen plaintiff since May 1996. Deits noted that plaintiff had achieved his goal of obtaining 100 percent service-connected disability and medical retirement from the state and therefore plaintiff would probably not need additional counseling. Deits opined that plaintiff's prognosis was good if he could stay away from alcohol. AR 266.

On October 23, 1996, Deits noted that plaintiff had made contact with him "out of the blue." The point of plaintiff's visit was to reestablish regular visits with Deits so that he could report to the Veterans Administration rating board that plaintiff was in regular counseling; he also wanted to be seen to influence the Social Security Administration. Plaintiff also noted that fall was a bad time of year for him. AR 435-46.

Plaintiff saw psychologist Dr. Michael Sweet at the Veterans Hospital in Madison on October 29, 1996. Plaintiff reported that he had made progress communicating with his family and dealing with his need to isolate. He reported that he golfed and was a volunteer driver. He also indicated that he was interested in setting up a veterans' group in Dodgeville with the help of a friend. Plaintiff stated that he had prescriptions from Dr. Bishop for Prozac and Xanax but that he only took them when he anticipated stressful situations. He indicated that he was still having problems with insomnia and nightmares. Dr. Sweet

diagnosed chronic PTSD. He gave him a score of 75-80 on the Global Assessment of Functioning Scale, indicating that plaintiff had no more than slight impairment in his social or occupational functioning. AR 294.

On November 7, 1996, Deits indicated that as a result of establishing a 100 percent service-connected disability rating for PTSD, plaintiff was in a situation where he could not afford to get better. He noted that plaintiff's agenda was to reinforce his disorder, a goal that Deits opined was contradictory to counseling and treatment. AR 434.

Dr. Bishop completed a psychiatric questionnaire for the state disability agency on November 1, 1996. Dr. Bishop indicated that he saw plaintiff every one to three months. He noted that plaintiff suffered from PTSD with associated poor short term memory, flashbacks, social withdrawal, insomnia, nightmares and weekly panic attacks. Dr. Bishop reported that plaintiff progressing well, noting that he had been involved in work around the house and worked on a computer frequently. AR 289-91.

At a visit with Dr. Sweet on November 11, 1996, plaintiff reported that his symptoms were generally stable. He indicated that he was going to spend three weeks at his condominium on the Gulf Coast as a substitute to his old habit of "taking off" to deal with his PTSD symptoms. He discussed the possibility of returning to school. He denied problems with alcohol but reported that he was still having sleep difficulties. AR 293.

At a meeting with plaintiff on January 7, 1997, Deits delivered to plaintiff a letter stating that plaintiff was in counseling with him at the Veterans Center on a regular basis.

In his notes from that meeting, Deits indicated that he had "stretched" the truth in his letter, noting that he had been seeing plaintiff only infrequently as a result of plaintiff's vacation and a family illness.

On March 3, 1997, Robert Hodes, Ph.D., a consulting psychologist for the state disability agency, reviewed plaintiff's records and concluded that plaintiff was capable of routine, unskilled work. Dr. Hodes noted that records indicated that plaintiff was progressing well with treatment and was performing recreational and volunteer activities. He also noted that although plaintiff reported sleep disturbances, his mood was stable with a full affect and normal cognitive functions. On June 17, 1997, Jack Spear, Ph.D., affirmed the decision as written. AR 300-313.

On March 20, 1997, Deits closed out his file, noting that he had not had any contact from plaintiff since January. He surmised that this may have been a result of reports he sent to the state medical disability board and the social security administration indicating that plaintiff had not been consistent in aftercare treatment. AR 431.

Plaintiff did not receive any psychotherapy or counseling until he saw Dr. Sweet on August 26, 1997. On that date, plaintiff reported that he was concerned about his "yearly slide" into depression in the fall and wanted to talk out some of his PTSD issues. He reported that he saw Deits from time to time and had a small network of Vietnam veteran friends to whom he talked on the phone and with whom he met occasionally for support. Plaintiff reported having had a recent flashback incident during a walk in the woods in Door

County. He also reported that things were going better with his wife and that he was able to get away on a "planned basis." Dr. Sweet recommended that plaintiff see his family doctor about possible medication changes to deal with seasonal depression and that he engage in a regular exercise program. AR 387.

That same day, plaintiff saw Deits and requested that they resume regular meetings. Deits saw plaintiff at his home the next day. Plaintiff reported that things were getting "loose," describing the flashback incident in Door County. AR 428-30. However, plaintiff did not show up for his next scheduled visit.

On September 13, 1997, plaintiff was evaluated by Dr. Michael Primc in connection with his veterans disability benefits. Plaintiff reported that he still experienced symptoms of PTSD, such as flashbacks, nightmares, insomnia and anxiety, but indicated that he had a better ability to cope with the symptoms. Plaintiff reported that he saw Dr. Sweet once a month for psychotherapy. Dr. Primc concluded that plaintiff's symptoms continued to meet the criteria for chronic PTSD. He concluded that as a result of the disorder, plaintiff had a moderate to severe restriction of his daily activities, a moderate constriction of his usual interests and a moderate difficulty and inability relating to others. He gave plaintiff a GAF score of 45, indicating serious symptoms, and opined that this was the highest level at which plaintiff had functioned in the past year. On the basis of Primc's report, the Veterans Administration found that plaintiff's post traumatic stress disorder continued to be 100 percent disabling. AR 385-86.

On September 25, 1997, plaintiff saw Dr. Sweet. Plaintiff reported increased sleep disturbance, fatigue and lack of focus during the day which he attributed to various family stressors. Plaintiff reported that he had been involved in helping his wife develop a business venture that involved creating websites for businesses as well as selling cheese products over the internet. He indicated that he had been taking calls, shipping merchandise and calling potential clients. Sweet rated plaintiff's GAF score in the past month as 80. AR 384.

From January 29 to February 4, 1998, plaintiff was hospitalized in Tomah for a "time out" in connection with his PTSD symptoms. Plaintiff reported that he had been feeling overwhelmed with everyday life and had resorted to his old pattern of running away and isolating himself in a motel room to deal with his symptoms. AR 407-408. The staff physician who completed the discharge summary of plaintiff's stay gave him a GAF score of 50, indicating moderate to serious functional impairments.

On February 9, 1998, Dr. Bishop completed a questionnaire on which he indicated that plaintiff exhibited various symptoms of anxiety and depression. He opined that although plaintiff was able to understand, carry out and remember simple instructions, he was unable to respond appropriately on a sustained basis to supervisors or coworkers, could not respond appropriately to ususal work situations and could not deal with changes in a routine work setting. He opined that plaintiff had marked restrictions in his activities of daily living, ability to maintain social functioning and ability to maintain concentration,

persistence or pace, and had extreme episodes of deterioration or decompensation in work or work-like settings. AR 416-19.

On March 24, 1998, Dr. Sweet completed a mental residual functional capacity questionnaire on which he opined that plaintiff had severe restrictions in his ability to perform the mental demands of work. AR 424-26.

IV. Vocational Evidence

John Meltzer testified as a neutral vocational expert at the administrative hearing. In response to questioning by the ALJ, Meltzer testified that a hypothetical individual of plaintiff's age, education and prior work experience with the physical ability to perform medium work but who was mildly limited in the ability to maintain attention and concentration for extended periods; mildly limited in the ability to perform activities within a schedule, maintain regular attendance and be on time; mildly limited in the ability to complete a normal work day and work week without interruptions from psychologically based symptoms and to perform at a consistent pace without unreasonable number and length of rest periods; mildly limited in the ability to accept instructions and respond appropriately to supervisors; mildly limited in the ability to get along with co-workers or peers without distracting them or exhibiting behavioral extremes; and mildly limited in the ability to changes in the work setting would be able to perform jobs in the regional economy. Meltzer testified that such jobs included assembler, of which there were 11,000 jobs in

Wisconsin; hand packager, 4,300 jobs; delivery driver, 43,000 jobs; and janitor/cleaner, 48,000 jobs. Meltzer testified that all employment would be precluded if the hypothetical claimant missed work more than two days a month because of psychologically-based symptoms. Further, he testified that if the hypothetical was modified to include the symptoms described by plaintiff during his testimony, there would be no jobs available.

V. The ALJ's Decision

The ALJ evaluated plaintiff's application for benefits by following the five-step sequential evaluation procedure prescribed by the Social Security Administration. The ALJ concluded that plaintiff had severe impairments, alcoholism and post-traumatic stress disorder, but neither was so severe alone or in combination as to meet or equal a listed impairment. *See* 20 C.F.R., Appendix 1, Subpart P, Regulations No. 4. Utilizing a Psychiatric Review Technique Form, the ALJ found that although plaintiff met the Paragraph A diagnostic criteria for a substance addiction disorder and post traumatic stress disorder, he did not meet any of the Paragraph B criteria. The ALJ concluded that plaintiff had only slight limitations in activities of daily living, slight to moderate limitations in social functioning; seldom had limitations in concentration, persistence or pace; and only one or two episodes of mental deterioration or decompensation.

The ALJ then assessed plaintiff's residual functional capacity for work. He concluded that plaintiff had the residual functional capacity to perform the physical exertional and

nonexertional requirements of medium work except for mild limitations in his ability to maintain attention and concentration for extended periods; perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances; accept instructions and respond appropriately to criticism from supervisors; get along with coworkers or peer without distracting them or exhibiting behavioral extremes; respond appropriately to changes in the work setting; and complete a normal workday and workweek without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods. In reaching this conclusion, the ALJ rejected the March 24, 1998 residual functional capacities assessment signed by Sweet, finding that inconsistencies on the form provided a "valid basis to doubt that all the information contained on that form was actually provided by Dr. Sweet." AR 18. Specifically, the ALJ observed that the checklist portion of the form was completed in blue ink, Dr. Sweet's signature was written in black ink, and the fill-in sections of the form had been typewritten. The ALJ also found that the severity of plaintiff's limitations as identified on the form were inconsistent with Sweet's clinical notes in which he reported that plaintiff's PTSD was stable. In particular, noted the ALJ, Sweet concluded after his last clinical interaction with plaintiff that plaintiff was functioning around 80 on the GAF scale, which indicated that plaintiff had no more than minimal to slight impairments in social, occupational or school functioning.

The ALJ also rejected Dr. Bishop's conclusion that plaintiff's functional limitations were disabling. The ALJ noted that Dr. Bishop was plaintiff's family physician and was treating plaintiff mainly for physical complaints, whereas plaintiff was receiving most of his mental health treatment through the Veterans Administration Medical Center. Additionally, the ALJ observed that Dr. Bishop's contemporaneous medical reports did not contain findings sufficient to support his opinion and that they dealt primarily with physical complaints. The ALJ noted that on December 27, 1996, Dr. Bishop found that the plaintiff was doing well and that his condition was stable.

Finally, the ALJ found that Dr. Bishop's opinion was inconsistent with the other evidence in the record that showed that plaintiff only had slight to moderate functional limitations. In this regard, the ALJ noted that plaintiff participates in a wide variety of activities including driving, golfing, doing yard work, reading, volunteer work, housework and helping his wife with her internet business. In terms of his social functioning, the ALJ noted that plaintiff's treatment providers during his inpatient stays at the Veterans Hospital described him as cooperative, pleasant and able to get along well with others; that plaintiff had expressed an interest in starting a PTSD support group in his area and was already getting together informally with other veterans; that plaintiff occasionally drove other veterans to the hospital in Tomah on a voluntary basis; and that plaintiff liked to go golfing. The ALJ found that plaintiff's complaints of disabling limitations were not entirely credible, noting that plaintiff had only occasional medical visits and had stopped participating in

counseling once his disability rating was increased to 100 percent; that plaintiff's counselor had described him as "adept at playing the system in terms of portraying symptoms and documenting his disability;" and that plaintiff had no incentive to reenter the workforce as a result of the substantial income–over $4,000 per month–that he already was receiving from other disability payments.

The ALJ determined that psychologist Robert Hodes's March 3, 1997 report on plaintiff's functional limitations was most consistent with the record as a whole. Accordingly, the ALJ used this report to determine plaintiff's actual limitations when the ALJ prepared his residual functional capacity assessment. Combining this with the vocational expert's testimony, the ALJ found that although plaintiff's mental limitations precluded him from performing his past work, there were a significant number of unskilled jobs in the regional economy that plaintiff could perform despite his limitations.

The ALJ made the following specific findings:

> 1) The claimant met the disability insured status requirements of the Act on December 1, 1995, the date the claimant stated he became unable to work, and continues to meet them through December 31, 2000.
>
> 2) The claimant has not engaged in substantial gainful activity since December 1, 1995.
>
> 3) The medical evidence establishes that the claimant has severe post traumatic stress disorder and alcohol dependency (in remission), but that he does not have an impairment or combination of impairments listed in, or medially equal to one listed in Appendix 1, Subpart P, Regulations No. 4.

4) When the claimant's complaints and allegations concerning the impairments and limitations are considered in light of all objective medical evidence, as well as the record as a whole, they do not show that he is so severely impaired by mental and physical discomfort that he is incapable of engaging in all substantial gainful activity.

5) The claimant has the residual functional capacity to perform the physical exertion and nonexertional requirements of medium work except for mild limitations in his ability to maintain attention and concentration for extended periods, to perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances, to accept instructions and respond appropriately to criticism from supervisors, to get along with coworkers or peers without distracting them or exhibiting behavioral extremes, to respond appropriately to changes in the work setting, and to complete a normal workday and workweek without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods (20 CFR 404.1545).

6) The claimant is unable to perform his past relevant work as job service specialist or truck driver.

7) The claimant's residual functional capacity for the full range of medium work is reduced by the limitations set forth above.

8) The claimant is 54 years old, which is defined as closely approaching advanced age (20 CFR 404.1563).

9) The claimant has an eleventh grade education, defined as a limited education (20 CFR 404.1564).

10) The claimant does not have any acquired work skills which are transferable to the skilled or semiskilled work functions of other work (20 CFR 404.1568).

11) Based on an exertional capacity for medium work, and the claimant's age, education, and work experience, section

404.1569 and Rule 203.19, Table No. 3, Appendix 2, Subpart P, Regulations No. 4 would direct a conclusion of "not disabled."

12) Although the claimant's additional nonexertional limitations do not allow him to perform the full range of medium work, using the above-cited rule 203.19 as a framework for decision making, there are a significant number of jobs in the national economy which he could perform. Examples of such jobs are: assembler (11,000 in the Wisconsin economy); hand packager (4,300 in the Wisconsin economy); and janitor (48,000 in the Wisconsin economy).

13) The claimant was not under a "disability," as defined in the Social Security Act, at any time through the date of this decision (20 CFR 404.1520(f)).

AR 21-22.

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 him from performing past relevant work. If he can show this, the burden shifts to the Commissioner to show that plaintiff was 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. Weighing of Medical Opinions

Plaintiff contends that the ALJ erred by discrediting the reports of Dr. Sweet and Dr. Bishop indicating that plaintiff has severe limitations in his ability to perform the mental

demands of work. According to plaintiff, the ALJ was obligated under the regulations concerning treating source opinions to give controlling weight to these opinions. *See* 20 C.F.R. § 404.1527(d)(2). Moreover, argues plaintiff, the ALJ was obligated to recontact the physicians if he had questions about the bases for their opinions. Plaintiff contends that it was particularly inappropriate for the ALJ to discredit Dr. Sweet's report on the basis of his belief that it had been completed by someone else without first asking Dr. Sweet to clarify the ambiguities on the form.

The Commissioner's rules for evaluating medical opinions are set forth at 20 C.F.R. § 404.1527. The regulation provides that the opinion of a claimant's treating physician is generally entitled to more weight than those of non-treating physicians. However, the adjudicator will give a treating source's opinion controlling weight only if it is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is consistent with the other substantial evidence in the record. *See* 20 C.F.R. 404.1527(d)(2). If the treating physician's opinion is not entitled to controlling weight, the ALJ will determine independently the weight to give the opinion on the basis of the following factors: the length, frequency, nature and extent of the treatment relationship; the degree to which the medical signs and laboratory findings support the opinion; the consistency of the opinion with the record as a whole; and the specialization of the physician. *See* 20 C.F.R. § 404.1527(d)(2)-(5).

Contrary to plaintiff's contention, the regulations do not require the ALJ to recontact the treating physician simply because he may have provided evidence that is internally inconsistent or inconsistent with other evidence in the record. To the contrary, the regulations provide that "[i]f any of the evidence in [the claimant's] case record, including any medical opinions(s), is inconsistent with other evidence or is internally inconsistent, [the ALJ] will weigh all of the evidence and see whether [he] can decide whether [the claimant is] disabled based on the evidence [in the record]." 20 C.F.R. § 404.1527(c)(1). The ALJ will try to obtain additional evidence only if the evidence before him is insufficient to determine whether a claimant is disabled or, if after weighing the conflicting evidence, she cannot reach a conclusion. 20 C.F.R. § 404.1527(c)(3); *Luna v. Shalala*, 22 F.3d 687, 693 (7th Cir. 1994); *see also* 20 C.F.R. § 404.1512(e) (ALJ required to recontact treating physician when evidence received "is inadequate for [the ALJ] to determine whether [the claimant is] disabled."). In that situation, the ALJ will either request additional existing records, recontact the claimant's treating sources or any other examining sources, or ask the claimant for more information or to undergo a consultative examination. *Id.*; 20 C.F.R. § 404.1512(e).

Here, the ALJ determined that he was able to reach a conclusion about plaintiff's disability claim on the basis of the existing evidence in the record. The Seventh Circuit has indicated that how much evidence an ALJ should gather is a subject on which the court "generally respect[s] the [ALJ]'s reasoned judgment." *Luna*, 22 F.3d at 692. Thus, the

question is not so much whether the ALJ should have recontacted plaintiff's treating physicians, but whether the evidence in the record provides sufficient support for the ALJ's conclusions.

Starting with Dr. Sweet, I agree with plaintiff to the extent he contends it was improper for the ALJ to discount Dr. Sweet's opinion on the basis of the ALJ's belief that the form dated March 28, 1998 appeared to have been completed by someone else. The ALJ's conclusion that fraud was afoot simply because different colored inks were used and some sections were typewritten is, without more, mere conjecture; as such, it is not a valid basis to reject Dr. Sweet's opinion.

The ALJ also rejected Dr. Sweet's report on the ground that it was inconsistent with the psychologist's notes from his last clinical visit with plaintiff. So, even though it was an unfair stretch for the ALJ to reject the form in part on the basis of its "questionable" authenticity, this court must defer to the ALJ's weighing of Dr. Sweet's opinion if the other reason he provided is supported by substantial evidence in the record.

It isn't. The ALJ found that the severe limitations identified on the form were "wholly inconsistent" with the clinical notes from Dr. Sweet that indicated that plaintiff's PTSD was stable. As the ALJ noted, the last clinical note from Dr. Sweet before the form was completed indicated that Dr. Sweet assigned plaintiff a score of 80 on the GAF scale, which denoted that plaintiff had minimal to slight impairments in social, occupational or

school functioning. This clinic note was dated September 25, 1997 and is the last clinic note from Dr. Sweet that is in the record.

So far, so good. However, the administrative record indicates that subsequent to his September 25, 1997 visit with Dr. Sweet, plaintiff was hospitalized at the Veterans Hospital in Tomah from January 29, 1998 to February 4, 1998. Plaintiff reported on admission that he had recently felt overwhelmed with everyday life and had reverted to his old pattern of running away to a motel room without telling anyone of his whereabouts. Plaintiff was admitted for a week-long "time out" and was advised to follow up with Dr. Sweet upon release. The physician who completed the final summary of plaintiff's hospitalization rated plaintiff's GAF score as 50, which indicates serious functional impairment.

The ALJ does not mention this evidence in his decision even though it could explain why Dr. Sweet concluded on March 24, 1998 that plaintiff's limitations were more severe than they had been on September 25, 1997. Although there are no clinic notes of any follow up visits with Dr. Sweet in the record or any proof that he was aware of plaintiff's hospitalization, plaintiff testified at the administrative hearing that he saw Dr. Sweet in April or May 1998. Could he be thinking of late March, before Dr. Sweet completed the form? I cannot tell from the record. At the least, plaintiff's testimony indicates that the clinic note of September 25, 1997 was not necessarily Dr. Sweet's "final word" regarding plaintiff's level of functioning.

Of course, it is possible that the ALJ did not view the evidence of plaintiff's hospitalization as relevant to the issue of disability or warranting such a significant change in Dr. Sweet's opinion. Unfortunately, we are unable to tell what weight the ALJ gave to this evidence because he never mentioned it. Perhaps the ALJ concluded that plaintiff– whose own counselor described him as "adept at playing the system in terms of portraying his symptoms and documenting his disability"– hospitalized himself solely to bolster his SSD application. This could be a reasonable conclusion, but absent any discussion of this evidence, we do not know how the ALJ weighed it. In fact, it seems the ALJ overlooked this evidence entirely: he expressly –and incorrectly– found that plaintiff had not required any further hospitalization or crisis intervention since he had been granted a 100 percent service-connected disability rating. AR 17.

"While an ALJ need not articulate his reasons for rejecting every piece of evidence, he 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. 2000); *see also Clifford v. Apfel*, 227 F.3d 863, 871 (7th Cir. 2000) (ALJ must consider "*all* relevant evidence" and may not analyze only that information supporting ALJ's final conclusion) (emphasis in original). Here, the evidence of plaintiff's 1998 hospitalization appears to be consistent with his claim that his PTSD symptoms fluctuate in severity, and it directly contradicts the ALJ's finding that plaintiff had not required any hospitalizations after being found totally disabled by the Veterans Administration. Further, the GAF score assigned to plaintiff at that time was

significantly lower than the level found by the ALJ to represent plaintiff's typical level of functioning. Most importantly, this evidence could support the otherwise unexplained discrepancy between Dr. Sweet's clinical notes and his March 28, 1998 assessment.

When the decision of the ALJ is "unreliable because of serious mistakes or omissions, the reviewing court must reverse unless satisfied that no reasonable trier of fact could have come to a different conclusion, in which event a remand would be pointless." *Sarchet v. Chater*, 78 F.3d 305, 308 (7th Cir. 1996). Although the ALJ's conclusion that plaintiff is not disabled is generally supported by the record, for the reasons just stated I am not satisfied that the outcome would not have been different if the evidence of plaintiff's January 1998 hospitalization had been considered. Accordingly, I recommend that this court remand this case to the Commissioner for a proper evaluation of this evidence and for reconsideration of Dr. Sweet's opinion. To the extent he deems it necessary, the Commissioner may want to obtain additional evidence from Dr. Sweet.

Finally, I find that the ALJ properly concluded that Dr. Bishop's opinion was entitled to little weight because it was not well-supported by his clinical notes and because Dr. Bishop treated plaintiff primarily for physical complaints. *See* 20 C.F.R. § 404.1527(d)(2)-(5) (listing factors ALJ must consider when weighing medical opinions). This is not a basis to reverse the Commissioner's decision.

RECOMMENDATION

Pursuant to 28 U.S.C. § 636(b)(1)(B), I recommend that this court reverse the decision of the Commissioner denying Michael F. Perkins's application for social security disability insurance benefits and remand it to the Commissioner for proceedings consistent with this opinion.

Entered this 22nd day of August, 2001.

BY THE COURT:

STEPHEN L. CROCKER
Magistrate Judge