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

CAROLE J. ROWE,

Plaintiff,

v.

JO ANNE B. BARNHART,
Commissioner of Social Security,

Defendant.

REPORT AND
RECOMMENDATION

03-C-0118-C

REPORT

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 Carole J. Rowe appeals the Commissioner's determination that she is not entitled to disability insurance benefits under Title II of the Social Security Act, 42 U.S.C. §§ 416(i), 423(d), because she failed to show that she was disabled before her disability insured status expired on December 31, 1995. Because I conclude that substantial evidence in the record supports the Commissioner's determination, I am recommending that this court affirm the Commissioner's decision.

The following facts are drawn from the administrative record.

FACTS

I. Procedural History

Plaintiff applied for Disability Insurance Benefits on June 25, 1998, alleging that she had been unable to work since July 15, 1990 because of sarcoidosis, fibromyalgia and a leaky

mitral valve. The state disability agency denied plaintiff's claim initially and on reconsideration on the ground that the medical evidence was insufficient to show that plaintiff had a severe medical condition before December 31, 1995, the date on which her status as an insured individual under Title II of the Act expired.

Plaintiff had previously filed a separate application for Supplemental Security Income benefits under Title XVI of the Act on April 27, 1998. The state disability determination service found that plaintiff was disabled as of April 1, 1998 for the purposes of that application.[1]

Plaintiff requested an administrative hearing on her claim for DIB benefits. A hearing was held on February 11, 2000, at which plaintiff appeared with an attorney and testified. On July 7, 2000, the administrative law judge issued a decision finding that plaintiff was not entitled to DIB benefits. Like the local disability agency, the ALJ found that plaintiff had failed to establish that she had any medically determinable impairment that was "severe" before December 31, 1995. The ALJ's decision became the final decision of the Commissioner when the Appeals Council declined to review the ALJ's decision. This appeal followed.

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[1] In contrast to DIB under Title II, which may be paid retroactively for up to 12 months prior to the filing of a DIB application, *see* 20 C.F.R. §§ 404.131, 404.315, SSI payments are not retroactive but are prorated for the first month for which eligibility is established after application, regardless how long the claimant may have suffered from a particular infirmity. *See* 20 C.F.R. § 416.335. Therefore, in SSI cases, it is generally not necessary for the Commissioner to determine the exact onset date of disability. *See* Soc. Sec. Ruling 83-20.

II. Medical Evidence

In February 1987, Richard Brasington, Jr., M.D., a rheumatologist, diagnosed plaintiff with fibromyalgia; he prescribed an anti-depressant medication and a non-steroidal anti-inflammatory medication, which provided some benefit. Plaintiff returned in April 1988, and Dr. Brasington commented that she was doing "fairly well." Plaintiff quit her job as a nurse's aid in July 1990.

In June 1992, Plaintiff was examined by Todd Earnhart, M.D., at the request of her vocational counselor. Dr. Earnhart previously had seen plaintiff between October 1988 and September of 1990, but records from those visits are not in the administrative record. Plaintiff presented a list of complaints that included chronic exhaustion, chronic diffuse pain, restless sleep, overheating, dizziness, clumsiness, poor concentration, heartburn, poor bladder control and other problems. Dr. Earnhart recalled that plaintiff's complaints of unremitting pain and fatigue were the same as those she had raised in the past, but "unlike in the past where she tried to remain at least somewhat active she now tells me that she is basically bedbound." AR 151. Dr. Earnhart's physical examination of plaintiff revealed that she had clear lungs, good range of motion of her back and all joints, and normal strength, reflexes, sensation, and gait.

Dr. Earnhart noted that plaintiff had been diagnosed with fibromyalgia, but that she did not quite fit the classic criteria because she did not have the classic trigger points. Dr. Earnhart further noted that plaintiff had a history of rheumatic mitral valve disease, but at

the time her heart condition was quite stable. He renewed plaintiff's prescriptions for an anti-depressant medication and a non-steroidal anti-inflammatory medication, and instructed plaintiff on health care maintenance. He also recommended that she obtain a repeat psychiatric evaluation, noting that she had been diagnosed in 1987 as having a psychogenic pain and dependent personality disorder. Plaintiff declined that evaluation.

Thereafter, in 1993, 1994, and 1995, Dr. Earnhart periodically renewed plaintiff's prescriptions over the telephone. Because she did not have medical insurance, plaintiff did not see Dr. Earnhart again until September 1995. In September 1995, plaintiff told Dr. Earnhart that her pain was "markedly better" since her last visit. Plaintiff attributed the improvement in her pain to the fact that she led a sedentary lifestyle, sleeping 10-12 hours a day and limiting her physical and social activities. Dr. Earnhart detected no abnormalities on physical examination. Dr. Earnhart recommended some follow up cardiac testing to monitor her mitral valve disease as well as some screening labs, but plaintiff declined most of them.

On May 21, 1996, nearly five months after her insured status expired, plaintiff saw Dr. Mark Hennick for complaints of chest pain, inability to take a full breath, coughing, fatigue and malaise. After detecting no chest or heart abnormalities on physical exam, Dr. Hennick opined that plaintiff's "multiple atypical cardiopulmonary complaints" were probably panic symptoms or signs of a mood disorder. However, he recommended a chest x-ray and an EKG to rule out any cardiopulmonary disease. Plaintiff refused an EKG, but agreed to a chest x-ray and lab tests. Results of those tests were essentially normal.

Plaintiff saw Dr. Brasington on May 31, 1996 to discuss her concerns with severe weakness and fatigue. Plaintiff reported having gone on a special diet in April 1995 and that her pain was down to a 1 or 2 compared to the 10 that it had been previously. Plaintiff reported that she was able to garden at times and was able to paint one room in her house by working for very short periods of time.

On September 16, 1996, plaintiff saw Dr. Jerry Goldberg, a rheumatologist who had assumed her care after Dr. Brasington left the practice. Dr. Goldberg noted that plaintiff had a long history of diffuse pain characterized as fibromyalgia and rheumatic heart disease. He noted that plaintiff reported chronic chest pain and chronic profound fatigue that was often incapacitating. Dr. Goldberg recommended that plaintiff undergo further evaluation for systemic lupus or other problems, but plaintiff declined.

Eventually, Dr. Goldberg was able to convince plaintiff to undergo additional studies. In December 1997, a CT scan of the chest revealed numerous nodes. Plaintiff underwent a biopsy (which resulted in numerous complications requiring hospitalization) and was eventually diagnosed with Grade I sarcoidosis.[2] Plaintiff subsequently began taking Prednisone for treatment of symptoms associated with breathing difficulties.

In a letter dated March 2, 2000, Dr. Goldberg summarized plaintiff's medical history based upon his review of plaintiff's chart and his evaluations of plaintiff. He noted that

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[2] A disease of unknown origin characterized by the formation of lesions composed of granulated nodules that can appear in almost any organ. *Dorland's Illustrated Medical Dictionary* 1485 (27th ed. 1988).

plaintiff first had been diagnosed with fibromyalgia in 1987 by her family practitioner, who detected tenderness in the soft tissue and joints in multiple areas in the body. Dr. Goldberg stated that plaintiff had continued to have the classic findings of fibromyalgia "throughout the last decade," including disturbed sleep, diffuse and severe soft tissue pain, stiffness in the joints and muscles and exacerbation of pain after minor exercise. He described the diagnosis of fibromyalgia as "absolute." With respect to plaintiff's chest symptoms in 1996, he indicated that although they were initially attributed to "psychogenic causes," they actually were secondary to plaintiff's sarcoidosis. Dr. Goldberg indicated that he could best date the onset of plaintiff's sarcoidosis to late 1995, early 1996, noting that "[t]he problem with dating it is that most of her symptoms were attributed to psychological or emotional or fibromyalgic causes rather than being evaluated as an organic process." AR 338. He also noted that testing in 1997 had confirmed that plaintiff had severe rheumatic heart disease, and that plaintiff subsequently had experienced several episodes of congestive heart failure. Dr. Goldberg opined that plaintiff was totally impaired as a result of her sarcoidosis, heart disease and fibromyalgia.

III. Plaintiff's Testimony

At the administrative hearing, plaintiff testified that she had pain, weakness, numbness and muscle spasms as a result of her impairments. She testified that she was unable to walk one city block or sit for more than two hours continuously. She testified that

her symptoms in 1995 were for the most part the same as they were at the time of the hearing. Plaintiff said her pain was actually a little better in 2000 because she had gone on a diet and reduced her activities so that she no longer did much of anything.

IV. Legal Framework and the ALJ's Decision

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). An impairment or combination of impairments cannot be the basis for a finding of disability under the Act unless it is "severe," which means that it significantly limits the claimant's physical or mental ability to do basic work activities. 20 C.F.R. § 404.1521.

The Commissioner's regulations establish a five-step sequential inquiry to determine whether a claimant is disabled:

(1) Is the claimant currently employed?

(2) Does the claimant have a severe impairment?

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

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

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

See 20 C.F.R. § 416.920.

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

In this case, the ALJ denied plaintiff's claim at step two. After reviewing the medical evidence, the ALJ found that it failed to show that plaintiff had a severe medically determinable impairment on or before December 31, 1995. The ALJ noted that plaintiff had not been diagnosed with sarcoidosis until 1997, and that Dr. Goldberg was unable to opine conclusively whether the onset of that condition was before 1996. With respect to plaintiff's rheumatic heart disease, the ALJ found that although that condition predated her date last insured, there was no evidence that the condition had caused more than minimal work-related limitations.

As for plaintiff's fibromyalgia, the ALJ noted that plaintiff had been diagnosed with that impairment in 1987. However, he found that the "specific basis" for that diagnosis was not clear from the record. The ALJ found it significant that Dr. Earnhart had noted in 1992 that plaintiff did not have the classic trigger points associated with fibromyalgia. In

addition, the ALJ noted that plaintiff did not seek regular medical attention for the condition and that when she did return to Dr. Earnhart in 1995, she reported marked improvement in her pain. The ALJ considered Dr. Goldberg's opinion that plaintiff has suffered from fibromyalgia for the past 10 years, but he rejected it on the ground that it was inconsistent with Dr. Goldberg's treatment notes from September and November 1997, on which he did not list fibromyalgia as a diagnosis. Finally, the ALJ noted that Dr. Goldberg had diagnosed plaintiff with a somatoform disorder and that plaintiff had been awarded Supplemental Security Income benefits on the basis of that impairment. However, the ALJ found that the record failed to contain evidence sufficient to support a finding that plaintiff had a somatoform disorder before December 31, 1995, noting that plaintiff had refused Dr. Earnhart's request in 1992 that she consider a psychiatric evaluation.

ANALYSIS

In a social security appeal brought under 42 U.S.C. § 405(g), this court does not conduct a new evaluation of the case but instead reviews the final decision of the Commissioner. This review is deferential: under § 405(g), the Commissioner's findings are conclusive if they are supported by "substantial evidence." *Clifford v. Apfel*, 227 F.3d 863, 869 (7th Cir. 2000). 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), this court cannot

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. *Clifford*, 227 F.3d at 869. 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 ALJ denies benefits, he must build a logical and accurate bridge from the evidence to his conclusion. *Zurawski v. Halter*, 245 F.3d 881, 887 (7th Cir. 2001).

The primary focus of plaintiff's appeal is her contention that the ALJ erred in failing to determine her onset date in accordance with Social Security Ruling 83-20. That ruling "state[s] the policy and describe[s] the relevant evidence to be considered when establishing the onset date of disability under the provisions . . . of the Social Security Act." SSR 83-20, http://www.ssa.gov/OP_Home/rulings/di/01/SSR83-20-di-01.html. As explained in SSR 83-20, determining the appropriate onset date of disability is important because it may affect the period for which the claimant may be paid and it may even determine whether or not the claimant is eligible for benefits at all. In this case, for instance, plaintiff had to establish the onset of a disability before December 31, 1995 in order to be eligible for disability insurance benefits.

According to SSR 83-20, in disabilities of nontraumatic origin, three factors are to be considered in determining the onset date: the applicant's allegations, work history, and

medical and other evidence. *Id*. SSR 83-20 describes the date alleged by the applicant as "[t]he starting point" in determining the onset date, and provides that that date "should be used if it is consistent with all the evidence available." *Id*. Another significant date that the ALJ should consider, if relevant, is the date the impairment caused the individual to stop work. *Id*. Finally, "[m]edical evidence is the most important factor, and the chosen onset date must be consistent with it." *Henderson ex rel. Henderson v. Apfel*, 179 F.3d 507, 513 (7th Cir. 1999). "In cases where there is no medical evidence as to the precise onset date, but where the disabling impairment seems to have occurred prior to the date of the first recorded medical examination, the ALJ 'should call on the services of a medical advisor' to help in making the necessary inferences." *Lichter v. Bowen*, 814 F.2d 430, 434 (7th Cir. 1987) (quoting SSR 83-20). SSR 83-20 does not relieve a DIB claimant of her ultimate burden to prove disability before expiration of disability insured status, but "only requires that the ALJ assist the claimant in creating a complete record." *Armstrong v. Commissioner of Social Security*, 160 F.3d 587, 590 (9th Cir. 1998). *See also Pugh v. Bowen*, 870 F.2d 1271, 1278 n. 9 (7th Cir. 1989) (when claimant's medical chronology is complete, ALJ need not call a medical expert). Plaintiff contends the ALJ committed an error of law when he failed to call a medical advisor.

The Commissioner responds that SSR 83-20 does not apply to this case. According to the Commissioner, determination of the proper onset date under SSR 83-20 is required only if the ALJ first finds that the claimant was disabled. The Commissioner maintains that

it was plaintiff's burden to show that she was disabled before her insured status expired, and the ALJ properly found that plaintiff had not met her burden. Accordingly, argues the Commissioner, because plaintiff failed to show that she was eligible for DIB, there was no reason for the ALJ to have established an onset date. (Whether plaintiff was disabled after December 31, 1995, but before April 1998 is immaterial; she would not be entitled to disability insurance benefits if she became disabled after expiration of her insured status, and she would not be entitled to supplemental security income prior to the month in which she submitted her application.)

Not so fast, argues plaintiff. She points out that the Commissioner found her disabled as of April 1, 1998, with respect to her SSI application. Plaintiff contends that the ALJ should have given that determination preclusive effect and started his analysis from there, applying SSR 83-20 to determine the precise onset date of that disability.

I conclude that the parties are both partly correct. Plaintiff is correct insofar as she contends that the ALJ should have applied collateral estoppel to the determination by the local disability agency that plaintiff was disabled from a somatoform disorder at least as of April 1, 1998, the month in which she filed her application for SSI. *See* 20 C.F.R. § 404.951(f) (ALJ is not to reconsider fact that has already been decided in previous determination or decision in claim involving same parties but different title of Social Security Act). After doing that, the ALJ should have followed the procedure set out in SSR 83-20 to determine the proper onset date for the purposes of disability insurance benefits.

(As noted previously, because SSI benefits are awarded as of the month in which the application was filed, the local disability agency did not have to determine the precise date of onset of that disability; April 1, 1998, merely represents the first date on which plaintiff was *eligible* for SSI, not the actual onset date of her disability, so that question remained open. *See* SSR 83-20.) However, this applies only to the evidence with respect to plaintiff's somatoform disorder. The local disability determination service apparently found that plaintiff had not established that she was disabled from fibromyalgia, mitral valve prolapse or sarcoidosis, either before December 31, 1995 for the DIB claim, or in April 1998 for the SSI claim. Accordingly, with respect to these impairments, defendant is correct that SSR 83-20 did not apply unless plaintiff first established that she was disabled by satisfying her burden of proof through step four of the sequential evaluation process.

In the end, however, it does not matter that the ALJ did not dissect plaintiff's claim in this fashion. Even assuming SSR 83-20 applied to all of plaintiff's impairments, plaintiff still had the burden to establish that she was disabled before her insured status expired. Moreover, the ALJ was not required to call a medical expert unless he concluded that the medical record was ambiguous concerning the onset date of plaintiff's impairments. It wasn't. Plaintiff submitted a detailed report from Dr. Goldberg in which he summarized plaintiff's medical history and offered his opinion regarding the onset date of her impairments. The ALJ did not need to call a medical expert when the record already contained a medical opinion from plaintiff's treating physician regarding onset date. Dr.

Goldberg's detailed report, along with the medical records, were sufficient to allow the ALJ to make an "informed judgment" about the onset date of plaintiff's impairments. This is all that SSR 83-20 requires.

Accordingly, the issue is simply whether the ALJ's conclusion that plaintiff had failed to show that she was disabled before December 31, 1995 is supported by substantial evidence. Plaintiff challenges the ALJ's finding that she did not have a "severe" impairment before December 31, 1995. Plaintiff contends that in order to show that her impairments were severe, she had to show only that her impairments had "more than a minimal effect" on her ability to do basic work activities. *See* SSR 85-28 (an impairment(s) that is "not severe" must be a slight abnormality (or a combination of slight abnormalities) that has no more than a minimal effect on the ability to do basic work activities"). Plaintiff points to the records from Dr. Earnhart as evidence showing the presence of severe fibromyalgia before her date last insured.[3] She notes that in 1992, Dr. Earnhart documented that she complained of "severe unremitting pain and fatigue," noted that she had borderline positive blood tests in 1987 and 1988, prescribed amitryptiline and anti-inflammatories and diagnosed fibromyalgia. She also points out that Dr. Earnhart diagnosed fibromyalgia again when he saw her in 1995, and noted that plaintiff reported going to very few social events because it fatigued her afterwards.

[3] Apart from her contention that the ALJ should have called a medical expert, plaintiff has not challenged the ALJ's analysis with respect to her rheumatic heart disease, sarcoidosis or somatoform disorder.

As plaintiff points out, a claimant's burden to show the existence of a "severe" impairment at step two is not substantial. In close cases, the ALJ is to give the claimant the benefit of the doubt and proceed with the rest of the sequential evaluation process. *See* SSR 85-28 ("If an adjudicator is unable to determine clearly the effect of an impairment or combination of impairments on the individual's ability to do basic work activities, the sequential evaluation process should not end with the not severe evaluation step"). In light of this, I agree with plaintiff that the record in this case contains sufficient evidence to support plaintiff's contention that her ability to do basic work activities was more than "slightly" limited before December 31, 1995. However, the ALJ did not stop his analysis at step two only because he found that plaintiff's impairment was not "severe." He also found that the medical evidence did not establish the presence of a medically-determinable impairment.

Under the Commissioner's regulations, an impairment "must be established by medical evidence consisting of signs, symptoms, and laboratory findings, not only by [a claimant's] statement of symptoms." 20 C.F.R. § 404.1508. The ALJ found that the record in this regard was insufficient to establish that plaintiff had fibromyalgia before her insured status expired. The ALJ noted that although plaintiff carried the diagnosis of "fibromyalgia," Dr. Earnhart had observed that plaintiff did not have the classic trigger points that are typically associated with the disease. The ALJ also noted that Dr. Goldberg's opinion that plaintiff had had fibromyalgia for at least 10 years was inconsistent with some of his own

treatment notes from his initial evaluations of plaintiff on which he did not list fibromyalgia as a diagnosis. Earlier in his opinion, the ALJ noted that physical examinations and laboratory testing by Dr. Goldberg in November 1997 had revealed no abnormalities.[4] Although not glaring, these contradictions provide a sufficient foundation for the ALJ's decision to discount Dr. Goldberg's opinion and to conclude at step two that plaintiff had failed to establish that she had fibromyalgia before her insured status expired. *See* 20 C.F.R. § 404.1527 (ALJ may discount opinions from treating sources that are inconsistent with other evidence or not well-supported by medically acceptable clinical and laboratory diagnostic techniques); *Estok v. Apfel*,152 F.3d 636, 640 (7th Cir. 1998) ("retrospective diagnosis may be considered only if it is corroborated by evidence contemporaneous with the eligible period").

Next, plaintiff contends the ALJ erred by failing to consider her obesity, either alone or as a factor that contributed to the severity of her other impairments. *See* 20 C.F.R. § 404.1523 (disability benefits can be awarded on basis of "medically severe combination of impairments"). Plaintiff did not mention obesity on her application for benefits or at any time before the ALJ, which means that she has probably forfeited this issue. *See Kepple v. Massanari*, 268 F.3d 513, 516-17 (7th Cir. 2001) (suggesting but not deciding that claimant

[4] The ALJ also noted that plaintiff did not seek treatment regularly for fibromyalgia or any other condition. However, the record indicates that plaintiff did not obtain regular health care because she did not have medical insurance and did not trust doctors. Accordingly, plaintiff's failure to obtain regular treatment provides little, if any, support for the ALJ's conclusion.

waives an issue by failing to raise it during administrative hearing). In any event, even if she has not waived the issue, the record is insufficient to establish that plaintiff suffered any disabling limitations as a result of her obesity. Although some clinicians described plaintiff as an "obese" female, no one prescribed any treatment or identified her obesity as a clinically significant problem. Furthermore, plaintiff did not present any testimony or evidence at the administrative hearing that her obesity impaired her ability to work. In the face of this silent record, the ALJ did not err in failing to consider plaintiff's obesity.

Finally, plaintiff argues that the Commissioner had to prove that she retained the residual functional capacity to perform work on a sustained basis. However, because the ALJ properly found that plaintiff did not have a severe, medically-determinable impairment before the expiration of her insured status, he terminated the sequential evaluation at step two. Therefore, it was not necessary for him to determine plaintiff's residual functional capacity, which is part of the step four analysis. *See* 20 C.F.R. § 404.1520(a); SSR 96-8p.

In sum, the record before the ALJ was developed adequately to allow him to make an informed judgment regarding whether plaintiff was disabled before her insured status expired. Substantial evidence supports his conclusion that the record failed to establish the presence of any medically determinable impairment or impairments that significantly limited plaintiff's ability to perform basic work-related activities on or before December 31, 1995. Accordingly, this court should affirm the Commissioner's decision.

RECOMMENDATION

Pursuant to 28 U.S.C. § 636(b)(1)(B), I respectfully recommend that the decision of the Commissioner denying plaintiff's application for Disability Insurance Benefits under Title II of the Social Security Act be AFFIRMED.

Entered this 8th day of September, 2003.

BY THE COURT:

STEPHEN L. CROCKER
Magistrate Judge