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

ROBERT E. SCHMIDT,

Plaintiff,

REPORT AND
RECOMMENDATION

v.

03-C-0281-C

JO ANNE B. BARNHART,
Commissioner of Social Security,

Defendant.

REPORT

This is an appeal of an adverse decision of the Commissioner of Social Security brought pursuant to 42 U.S.C. § 405(g). Plaintiff Robert E. Schmidt appeals a final decision of the Commissioner finding that he was not disabled and therefore not eligible for Disability Insurance Benefits or Supplemental Security Income under sections 216(i), 223 and 1614(a)(3)(A) of the Social Security Act, codified at 42 U.S.C. §§ 416(i), 423(d) and 1382c (a)(3)(A). Plaintiff asks this court to remand his case to the Commissioner pursuant to sentence six of 42 U.S.C. § 405(g) for consideration of evidence that plaintiff contends is new and material to the application decided by the ALJ. Alternatively, he seeks a remand under sentence four of § 405(g) on the ground that the ALJ's decision is not supported by substantial evidence.

This court should reject plaintiff's request for a sentence six remand and affirm the decision of the Commissioner. Plaintiff's additional evidence fails to satisfy the criteria for

remand because it either postdates the time period under consideration by the ALJ or it was available to plaintiff at the time of the administrative proceedings. Plaintiff's request for a sentence four remand fails as well because substantial evidence in the record adequately supports the ALJ's conclusion that plaintiff was not disabled at any time up to the date of the ALJ's decision.

The following facts are drawn from the administrative record:

FACTS

I. Background and Work History

Plaintiff was born on September 21, 1950, making him fifty years old on the date of the ALJ's decision. Plaintiff has a college education, having earned a degree in psychology. He has past relevant work experience as a group home manager, data entry clerk, childcare worker, department store salesperson and general laborer. However, many of these jobs were short-term and interspersed with lengthy periods of unemployment. His longest term of employment was from October 1993 to July 1995, when he was employed as a floor sales associate for Wal-Mart. On May 7, 1999, plaintiff applied for social security benefits, alleging that he had been disabled since December 23, 1998 from generalized anxiety disorder with panic attacks, irritable bowel syndrome with chronic fatigue and a slipped disc in his lower back.

II. Medical Evidence

The medical records in the administrative record date back to March 1992. At that time, plaintiff was seen by a rheumatologist for complaints of musculoskeletal pain, irritable bowel symptoms including alternating periods of constipation and diarrhea and other various somatic complaints. Laboratory studies were all normal except for high cholesterol. Spine x-rays showed spondylolysis and Grade I spondylolisthesis at L5-S1, an abnormality the rheumatologist described as "not serious." The rheumatologist opined that plaintiff's multiple pain complaints were "benign" and could be helped by physical therapy, better sleep and a job.

On June 3, 1994, plaintiff was admitted to the hospital after presenting to the emergency room for complaints of left-sided weakness and headache. A psychiatric consultation was obtained after neurological, physical examination and laboratory studies were all normal. Plaintiff stated that he had an anxiety disorder since early childhood. Plaintiff reporting having attacks characterized by anxiety, hyperventilating, light-headedness and difficulty breathing. Plaintiff stated that his emergency room visit had been precipitated by his receipt of a poor performance review at work, an event that was very upsetting and stressful for plaintiff. Plaintiff reported that although he had been treated with medication for his intense anxiety during his college years, he had been off antidepressants until 1992, when his primary physician had prescribed amitriptyline. According to plaintiff, the amitriptyline had been quite helpful in managing his anxiety. Plaintiff was diagnosed with

an anxiety disorder and a schizotypal personality disorder. He was released after one day in the hospital and advised to increase his dose of amitriptyline and return for psychiatric testing and outpatient treatment.

The next medical records in the file are from 1998. On November 5, 1998, plaintiff saw his primary physician, Dr. Joseph Cabaltica, for complaints of panic attacks. Plaintiff reported that he had been doing well for a while but that his panic attacks had returned. He was taking one or two Xanax as needed for the attacks. Neurological examination revealed no focal findings. Dr. Cabaltica told plaintiff to keep taking Xanax as needed.

On February 23, 1999, plaintiff went to the emergency room reporting that he had had irritable bowel symptoms for the past two and a half months and had recently noticed some bleeding. He was anxious and his abdomen was mildly tender. Emergency room staff diagnosed plaintiff with irritable bowel syndrome and anxiety and administered toradol.

Plaintiff went to the emergency room again on March 30, 1999, with complaints of chest pain, hyperventilation and anxiety. An EKG was normal. Plaintiff was advised to take his Xanax as needed and to follow up with Dr. Cabaltica if necessary.

In early April 1999, plaintiff saw Dr. Cabaltica for complaints of sporadic right-sided chest pain and right shoulder pain that was unrelated to eating or activity. The pain worsened over the next two weeks, resulting in plaintiff's admission to the hospital on April 19, 1999. Laboratory tests including an upper GI series were normal, with no signs of gastric outlet obstruction. An ultrasound revealed no abnormalities in the abdominal aorta,

pancreas or kidneys. Plaintiff's white blood cell count was high on admission, but by the next day was much lower. Plaintiff was diagnosed with acute pancreatitis that had improved within one day of admission. He was treated with IV fluid. After two days in the hospital, plaintiff was feeling much better and was sent home with instructions to avoid greasy foods, alcohol and Tylenol.

At a follow-up visit with Dr. Cabaltica on April 28, 1999, plaintiff reported that he was doing better since his discharge from the hospital. Dr. Cabaltica noted that plaintiff's pancreatitis was probably a result of plaintiff's high cholesterol and triglycerides. Dr. Cabaltica prescribed Lipitor and advised plaintiff to follow a low cholesterol, low carbohydrate diet. In addition, he prescribed a muscle relaxant for plaintiff's shoulder pain.

Dr. Edward Root, a psychiatrist, evaluated plaintiff on May 18, 1999. Plaintiff reported a history of anxiety with panic attacks that had begun to recur in October 1998. Plaintiff stated that during a panic attack, he hyperventilates, can't think clearly, has chest pain and a rapid heartbeat, and feels like he is going to die. Dr. Root described plaintiff as well kempt and having a sense of humor. He found plaintiff's cognition and memory to be quite good, but his insight and judgment to be slightly decreased. Plaintiff complained that he had difficulty keeping his thoughts if he was distracted, but Dr. Root found no evidence of any formal thought disorder. Dr. Root opined that plaintiff had dysthymia and a panic disorder without agoraphobia. He gave plaintiff a score of 55 on the Global Assessment of Functioning Scale, indicating the presence of moderate symptoms. *See Diagnostic and*

Statistical Manual of Mental Disorders at 34 (4th ed. [text rev.] 2000). Dr. Root recommended that plaintiff switch from Xanax to Lorazepam for treatment of the panic attack symptoms. He also recommended a trial of Celexa to try to prevent the panic attacks from recurring.

At a follow up visit with Dr. Root on June 22, 1999, plaintiff reported that he was doing well with his panic attacks. He reported having had a few "mini" attacks but that he had prevented them from turning into full-blown panic attacks by taking a Lorazepam tablet. Plaintiff stated that he had not tried the Celexa but had been taking three tablets of St. John's Wort instead. He said the St. John's Wort helped his anxiety. Plaintiff was looking for a nonstressful job and was interested in establishing a drop-in support center for the chronically mentally ill. Dr. Root diagnosed dysthymia. He also noted that "to some extent, [plaintiff] suffers from agoraphobia, particularly with regards to taking on certain jobs."

On August 4, 1999, plaintiff was examined by Dr. Bahri Gungor at the request of the Social Security Administration. Plaintiff was unemployed and complaining of pain in his lower back and in the upper part of his back on the right side radiating to the right lateral chest. Plaintiff reported that he had been told by a physician that a disc was pressing on his sciatic nerve. Plaintiff also stated that in 1992 his family physician and a gastroenterologist had diagnosed him with irritable bowel syndrome and chronic fatigue syndrome. Plaintiff reported that his doctors had ruled out ulcerative colitis or Crohn's Disease. In addition, plaintiff stated that he had had a panic disorder since he was a child. Plaintiff told Dr.

Gungor that he had had three major panic attacks in the past year for which he had been treated at the emergency room.

Plaintiff described a sporadic work history. He stated that after receiving his degree, he worked in human services for two years but quit because it was too stressful, causing him to have more panic attacks, diarrhea and abdominal pain. He had the same experience with his next job. His last full time job was as a floor salesperson for Wal-Mart, which ended in 1995. Plaintiff reported that more recently, he had completed a training program for learning how to handle mentally retarded people. He stated that there was presently no money available for the program, but that he would be hired when money was available.

Dr. Gungor's physical examination detected few abnormalities. Plaintiff had some tenderness in his abdomen. He had essentially full range of motion, except that some movements caused pain in back. Straight leg elevation on the right side was slightly limited and painful and knee jerk on the right knee was a little diminished compared to the left. X-rays of plaintiff's spine showed normal height and width of the vertebral bodies with normal intervertebral disc spaces. The report noted "undue prominence of the transverse process of L3," but found that the "significance of these findings is questionable." In the "Impression" section of his report, Dr. Gungor restated plaintiff's complaints: recurrent panic attacks with hyperventilation, fainting spells and chest pains; chronic low back pain; chest pain that started four months ago on the right posterior chest; and bouts of severe diarrhea with frequent bowel movements diagnosed as irritable colon syndrome. In addition,

Dr. Gungor added his own "personal" impression that plaintiff had an inadequate personality disorder associated with panic attacks and hyperventilation, fainting spells and chest pain. Dr. Gungor offered no opinion as to whether plaintiff had any limitations on his ability to work.

On August 17, 1999, Jean Warrior, Ph.D., a consultant for the Social Security Administration, reviewed plaintiff's file and concluded that although plaintiff had an anxiety-related disorder, the impairment was not severe. Warrior concluded that plaintiff's impairment only slightly restricted his daily activities, social functioning and concentration, persistence or pace, and never caused any episodes of deterioration or decompensation. Warrior completed a Psychiatric Review Technique Form on which she documented her findings. Another agency consulting physician, Dr. Robert Callear, concluded on that same date that although plaintiff had spondylolisthesis and irritable bowel syndrome, plaintiff was capable of performing work requiring lifting up to 20 pounds and sitting, standing or walking up to six of eight hours per day.

On September 15, 1999, plaintiff was seen in the emergency room complaining of having a panic attack with chest pain. He reported that he had taken a Lorazepam at home and was starting to feel better. Plaintiff appeared anxious but was otherwise oriented, alert and cooperative. An EKG showed no abnormalities. Plaintiff was given 5 milligrams of Haldol and released. However, plaintiff returned to the emergency room the next night complaining of the same symptoms. He reported "profound symptoms of depression,

decreased appetite, depressed, sleep disorder, denies suicidal ideation." Plaintiff was given a prescription for Lorazepam and advised to follow up with his family physician.

Plaintiff saw Dr. Root on October 21, 1999. Plaintiff reported that after the September emergency room visit, he had controlled his panic attacks by taking Lorazepam daily at 5 p.m. He was also using meditation and contemplation to help his anxiety. Dr. Root described plaintiff as "earnest and help-seeking and a bit keyed up" but "not having any anxiety attack per se." Dr. Root diagnosed panic disorder without agoraphobia. He recommended again that plaintiff try Celexa to help prevent the panic attacks and reduce his reliance on the Lorazepam; plaintiff said he would try this approach.

On December 22, 1999, consulting psychologist Henry Kaplan, Ph. D., certified that he had reviewed all of the evidence in plaintiff's file and agreed with the conclusions made by Warrior on the Psychiatric Review Technique Form.

Plaintiff saw Dr. Root on January 24, 2000. Plaintiff reported that the only medication he was taking for his anxiety was Lorazepam. Plaintiff said he had not used the medication for a couple weeks because he had been doing better with his anxiety. He described his anxiety as coming and going from time to time for unexplained reasons. He told Dr. Root that he had tried the Celexa for two days but discontinued it because it made him extremely anxious. Instead, he was taking St. John's Wort, which he reported had helped his anxiety. Plaintiff reported having been working at building his own "nutriceutical" company for the past two years; he was also working part-time for Figi's, a

mail-order catalog company. Plaintiff said he was feeling quite good except that sometimes he was awakened at night by stomach cramps that caused him to feel anxious. Dr. Root opined that plaintiff was more likely suffering from anxiety attacks rather than panic disorder. He noted that plaintiff was "not terribly needy from an anxiety point of view." He diagnosed plaintiff as suffering from "anxiety attacks ameliorated by Lorazepam [as needed] as well as St. John's Wort." Plaintiff had no further visits with Dr. Root.

III. Hearing Testimony

After the local disability agency denied plaintiff's applications initially and on reconsideration, plaintiff had a hearing on September 20, 2000, before an administrative law judge. Plaintiff was represented at the hearing by attorney James Connell. At the hearing, plaintiff testified that his last employment had been as a seasonal worker performing data entry for Figi's, a mail-order catalog company. Plaintiff testified that he had worked for Figi's from October 1999 to February 2000, when the company laid him off because of a lack of work. Thereafter, plaintiff applied for and began receiving unemployment compensation from the state of Wisconsin. Plaintiff testified that he had been looking for work but was having trouble finding a job because of his disability.

Plaintiff testified that while employed at Figi's, he had trouble performing his data entry job. He testified that his speed was "barely above" the minimum requirement and that he spent a lot of time in the bathroom because of his irritable bowel syndrome. Plaintiff

testified that although Figi's was very accommodating of people with disabilities, he was uncertain whether the company would rehire him given the difficulties he had had in 1999-2000.

Plaintiff testified that during the six weeks preceding the hearing, he had 12 panic attacks, two for which he sought treatment at the emergency room. The ALJ agreed to keep the record for 30 days open to allow plaintiff's attorney to submit additional medical records from those hospitalizations. Plaintiff's attorney submitted the records on November 30, 2000, outside the 30-day period. (It appears that these records were not considered by the ALJ; however, they were part of the record before the Appeals Council.) The records showed that plaintiff had presented to the emergency room on August 3, 2000, complaining of abdominal pain for the past five to seven days; plaintiff was diagnosed with irritable bowel syndrome and advised to follow up with Dr. Cabaltica. Plaintiff returned to the emergency room on August 4, 2000, reporting pain on his left side that radiated into his shoulder blade. He was advised again to follow up with Dr. Cabaltica. On August 12 and 16, 2000, plaintiff went to the emergency room reporting pain in his right side that was different from his irritable bowel syndrome pains; the pain was eventually determined to have been caused by a kidney stone. None of the records that plaintiff submitted after the hearing showed that he had been hospitalized for panic attacks.

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).

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 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).

On December 12, 2000, the ALJ issued a written decision in which he applied the sequential process for evaluating disability claims. At step one, he found that although plaintiff had alleged disability since December 23, 1998, he had performed substantial gainful activity from October 1999 until February 2000, at which point he had filed for and collected unemployment compensation. The ALJ found that plaintiff had not performed substantial gainful activity since February 2000.

At step two, the ALJ found that plaintiff had the following impairments: complaints of chronic low back pain secondary to Grade I L5-S1 spondylolisthesis; intermittent right shoulder pain, felt to be musculoskeletal in origin; irritable bowel syndrome associated with subjective complaints of fatigue; an anxiety-related disorder associated with occasional panic attacks with chest pain and hyperventilation; and a history of alcohol and drug abuse, in remission. At step three, the ALJ found that none of plaintiff's impairments, alone or in combination, met or equaled the criteria of any listed impairment.

At step four, the ALJ found that plaintiff could perform his past relevant work as a group home worker or data entry clerk. In reaching this conclusion, the ALJ found that plaintiff's subjective complaints of pain, fatigue and panic attacks were not fully credible and were not consistent with the objective medical evidence. The ALJ noted that x-rays of plaintiff's spine had revealed no major abnormalities and plaintiff was not receiving any

active treatment or therapy for either low back or shoulder pain; tests of plaintiff's gastrointestinal tract were essentially normal; physical examinations had revealed no musculoskeletal or sensory deficits; and the record contained no evidence to support plaintiff's allegations of chronic fatigue. As for plaintiff's panic attacks, the ALJ noted that they were well-controlled with medication and did not impose any significant work-related limitations. The ALJ noted that plaintiff had been diagnosed with irritable bowel syndrome, but found that he "denied symptoms of diarrhea." The ALJ credited the residual functional capacity assessments of the state agency consulting physicians, who opined that plaintiff could perform the full range of light work and was only slightly limited by his anxiety disorder.

Apart from the medical evidence, the ALJ cited various reasons for discounting the credibility of plaintiff's subjective complaints. The ALJ observed that plaintiff's daily activities were not significantly restricted, plaintiff was not under any active treatment or therapy for his conditions, plaintiff did not use any prescriptive pain medication and plaintiff had worked at the substantial gainful activity level after the date on which he alleged he was disabled. The ALJ noted that plaintiff's employment had been seasonal and ended only because he was laid off. In addition, the ALJ noted that plaintiff had applied for and collected unemployment compensation, which required him to certify that he was ready to work; also, plaintiff had been actively seeking other jobs since his layoff.

After comparing the physical requirements of plaintiff's past work with plaintiff's residual functional capacity for the full range of light work, the ALJ found that plaintiff could perform his past relevant work as a group home manager or a data entry clerk because neither of these jobs as plaintiff performed them required the performance of any tasks that were beyond his residual functional capacity. Accordingly, the ALJ ended his evaluation at step four, concluding that plaintiff was not eligible for either disability insurance benefits or supplemental security income.

V. Action Before Appeals Council

Plaintiff's attorney, Connell, requested the Appeals Council to review the ALJ's decision. In a letter dated January 23, 2001, he asked for a copy of the tape recording of the hearing; in addition, he stated his intent to submit additional evidence to support plaintiff's claim. On August 15, 2002, the Appeals Council mailed the cassettes to Connell and informed him that it would hold the record open for 25 days so he could submit additional evidence or legal argument. In the letter, it stated that if nothing was received in the next 25 days, or by September 9, 2002, "the Council will proceed with its action on this case based upon the present record." AR 12. The letter provided a fax number to which a response could be sent.

On September 9, 2002, at 3:02 p.m. CST, attorney Dana Duncan faxed a letter to the Appeals Council at the number provided in its letter of August 15, 2002. In the letter,

Duncan stated that plaintiff's 25-day period ended that day; plaintiff had been informed by attorney Connell that he could no longer represent him because of a conflict of interest; plaintiff had retained Duncan to replace Connell; and Duncan had not yet had an opportunity to obtain plaintiff's file or retrieve any new medical information. Duncan requested a 60-day extension of time so that he could obtain plaintiff's file and new medical information and prepare a brief.

The Appeals Council did not respond to Duncan's letter. On March 21, 2003, it issued an order denying plaintiff's request for review of the ALJ's decision. The letter was mailed to plaintiff, with a copy to attorney Connell.

ANALYSIS

I. Motion for Remand Under Sentence Six

Plaintiff asks this court to remand his case pursuant to sentence six of § 405(g) for consideration of additional evidence. Under sentence six, the district court may remand in light of additional evidence without considering the correctness of the Commissioner's decision, but only if the evidence is new and material and there is good cause for the failure to produce the evidence before the ALJ. *See Melkonyan v. Sullivan*, 501 U.S. 89, 100-01 (1991). Evidence is material if there is a "reasonable possibility" that its consideration would have changed the ALJ's decision. *Sears v. Bowen*, 840 F.2d 394, 400 (7th Cir. 1988). To be material, the evidence must "relate to the claimant's condition during the relevant time

period encompassed by the disability application under review." *Anderson v. Bowen*, 868 F.2d 921, 927 (7th Cir. 1989) (citations omitted).

The additional evidence submitted by plaintiff does not satisfy the criteria for a remand under sentence six. The evidence consists of medical records from the Marshfield Clinic from January 2002 through August 2003 and employment records from Figi's, plaintiff's last employer.[1] The medical records show that plaintiff began seeing Dr. Alpa Shah on December 4, 2001, for treatment of his panic disorder. On September 11, 2003, Dr. Shah completed a mental impairment questionnaire on which he indicated that plaintiff had marked functional limitations as a result of his mental impairment. None of these records are material because they postdate the administrative hearing. Although Dr. Shah opined on the questionnaire that plaintiff has had a severe panic disorder for at least two years, *see* Aff. of Dana Duncan, dkt. # 10, exh. D-3, or, in other words, since September 11, 2001, that date is still outside the time period under consideration by the ALJ. None of the medical records state that plaintiff suffered from a severe panic disorder during the period of time that the ALJ was considering. Absent a showing that the records speak to the severity of plaintiff's panic disorder during the time period at issue before the ALJ, they are not material.

[1] The additional medical records include notes of plaintiff's treatment for chronic sinusitis and respiratory infections. Plaintiff concedes that these records are not material to his application before the ALJ.

As for the vocational records from Figi Gifts, Inc., plaintiff has not made the requisite showings of newness and good cause. The records are from plaintiff's personnel file and predate the administrative hearing. Because these records were in existence and available to plaintiff at the time of the administrative hearing, they are not new. *Perkins v. Chater*, 107 F.3d 1290, 1296 (7th Cir. 1997) ("new" means evidence "not in existence or available to the claimant at the time of the administrative proceeding"). Plaintiff attempts to blame the Appeals Council for the omission of the Figi's reports from the administrative record, arguing that the Appeals Council failed to respond to Duncan's request that it postpone consideration of plaintiff's case so that Duncan could investigate the case and submit additional evidence. However, this goes to good cause, not newness. Furthermore, it does not explain why plaintiff's first lawyer did not obtain the records.

In any case, even if plaintiff could show that the employment records are new and that he had good cause for not submitting them at the administrative hearing, they are not material. Plaintiff argues that the records are material because they indicate that he struggled with production quotas in his job as a data entry clerk, evidence that plaintiff says contradicts the ALJ's finding that he could perform his past relevant work as a data entry clerk. However, the same report indicates that plaintiff was recommended for rehire in a different department despite his low production. Thus, these records tend to support the ALJ's decision that plaintiff was not disabled. Furthermore, as the Commissioner points out, the ALJ found that plaintiff could perform the full range of light work. This means that if

the ALJ would have proceeded to step five, he would still have found plaintiff not disabled pursuant to the Commissioner's medical-vocational guidelines. *See* 20 C.F.R. Pt. 404, Subpt. P, App. 2, Rules 202.13-15 (providing that an individual aged fifty with a high school education is not disabled if he can perform the full range of light work). Thus, the ALJ's ultimate conclusion that plaintiff is not disabled would not have been different even with the records from Figi's.

In sum, plaintiff has failed to demonstrate that his additional evidence satisfies the criteria warranting a remand under sentence six. The additional evidence was not new or would not have changed the outcome of his claim. In light of this conclusion, it is not necessary to address plaintiff's claim that the Appeals Council violated effectively either his right to have an attorney represent him or his right to present additional evidence when it failed to respond to Duncan's letter of September 9, 2002. Even if this court were to assume that the Appeals Council committed some error in failing to respond to Duncan's eleventh-hour letter, plaintiff was not prejudiced by it. Accordingly, there is no reason to remand this case under sentence six.

II. Review of ALJ's Decision

A. Standard of Review

Plaintiff argues that even if the court denies his request for remand under sentence six, it should remand the case for a new hearing under sentence four because the ALJ's decision is not supported by substantial evidence.

Under 42 U.S.C. § 405(g), the Commissioner's findings are conclusive if they are supported by "substantial evidence." *See Stevenson v. Chater*, 105 F.3d 1151, 1153 (7th Cir. 1997); *Brewer v. Chater*, 103 F.3d 1384, 1390 (7th Cir. 1997). "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). In addition, the court reviews the ALJ's decision to ensure that no errors of law occurred. *Dixon v. Massanari*, 270 F.3d 1171, 1176 (7th Cir. 2001).

B. Anxiety Disorder

Plaintiff's strongest argument in support of reversal under sentence four is his claim that substantial evidence does not support the ALJ's finding that his anxiety disorder was not a severe impairment. Under the regulations, a "non severe" impairment is "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." Soc. Sec. Ruling 85-28. 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"). As support for his contention that his panic disorder was a "severe" impairment, plaintiff points out that the record contains evidence showing that plaintiff went to the emergency room for panic attacks and that he reported having had three major panic attacks in October 1998.

The ALJ discussed this evidence in his decision. However, in concluding that plaintiff's panic disorder did not impose more than minimal work limitations, the ALJ cited to more recent evidence in the record that showed that plaintiff's panic attacks were well-controlled with medication. In particular, the ALJ noted that in January 2000 plaintiff had told Dr. Root, his treating psychiatrist, that he was feeling quite good and that prescribed medications and over-the-counter supplements were controlling his anxiety. At the time, plaintiff was working at Figi's and was also attempting to establish his own on-line "nutriceutical" company. The ALJ also noted that Dr. Root had indicated at that time that plaintiff was more likely experiencing anxiety attacks versus panic disorder. In addition, the ALJ noted that the state agency medical consultant, Jean Warrior, Ph. D., had reviewed the record and determined that plaintiff's mental condition imposed only slight functional limitations.

Plaintiff argues that this evidence does not adequately support the ALJ's finding that the panic disorder was not a severe impairment. Plaintiff points out that Dr. Root described

plaintiff's insight as being "somewhat limited;" according to plaintiff, this means that the ALJ should not have afforded much weight to plaintiff's reports about his condition. In addition, plaintiff argues that Dr. Root would have stopped prescribing medication for plaintiff if he thought his anxiety condition had completely resolved. These arguments are not persuasive. First, there is nothing in the record to support plaintiff's self-serving assertion that his reported "lack of insight" meant that his own statements regarding his condition could not be trusted. Second, the ALJ never found that plaintiff's anxiety condition had "completely resolved;" he simply found that it was under control with medication.

In any case, the task of this court merely is to decide whether substantial evidence in the record supports the ALJ's conclusion that plaintiff did not have a severe mental condition, not to rule out any other possible interpretations of the record. Even though there is evidence in the record that suggests that plaintiff's mental impairment during the time period under consideration might have been "severe" as that term is defined in the regulations, reasonable minds could conclude otherwise from Dr. Root's treatment notes, the opinions of the state agency consultants and plaintiff's ability to work despite his anxiety. In a case where "conflicting evidence allows reasonable minds to differ," this court must defer to the ALJ. *Walker v. Bowen*, 834 F.2d 635, 640 (7th Cir. 1987). Accordingly, the court should not remand the case on the basis of the ALJ's alleged failure to adequately evaluate plaintiff's mental impairment.

C. Irritable Bowel Syndrome and Fatigue

Next, plaintiff contends that the ALJ ignored evidence in the record related to his irritable bowel syndrome and fatigue. With respect to fatigue, the ALJ noted that "there was no evidence whatsoever to either identify or substantiate the claimant's allegations of chronic fatigue." Plaintiff challenges this finding, pointing out that "the claimant had several bouts of diarrhea." From this, plaintiff argues as follows: the record indicates that plaintiff was diagnosed with irritable bowel syndrome; fatigue is a symptom of irritable bowel syndrome; therefore, the ALJ's residual functional capacity assessment should have accounted for fatigue.

Plaintiff's argument is illogical. That some people who suffer from irritable bowel syndrome may have fatigue is irrelevant unless plaintiff actually has that symptom. And the fact that plaintiff may have had irritable bowel symptoms consisting of "several bouts of diarrhea" does not mean that he suffers from fatigue. To the contrary, as the ALJ noted, no medical provider ever noted fatigue as one of plaintiff's symptoms, much less prescribed any treatment for it.

That said, the ALJ was not entitled to disregard plaintiff's complaints of fatigue solely because they were not supported by objective medical evidence. *Knight v. Chater*, 55 F.3d 309, 314 (7th Cir. 1995); Soc. Sec. Ruling 96-7p. However, the ALJ did not do that in this case. The ALJ's remark concerning plaintiff's fatigue can fairly be read to refer both to the absence of objective evidence to support plaintiff's allegations and to the absence of any

evidence showing that plaintiff ever complained to any health care provider about fatigue. For example, although plaintiff told Dr. Gungor that he had been diagnosed with chronic fatigue syndrome (a statement that has no corroboration in the record) and outlined his various subjective complaints in detail, he did not allege any ongoing complaints of fatigue. Similarly, plaintiff did not report fatigue as a symptom during his initial evaluation with Dr. Root. As the ALJ observed, the medical records simply are at odds with plaintiff's allegations of severe and chronic fatigue. Furthermore, as the ALJ noted, plaintiff was able to work at the substantial gainful activity level as a data entry clerk despite his claim of disabling fatigue. This evidence goes beyond the objective medical evidence and fairly supports the ALJ's conclusion that plaintiff's complaints of disabling fatigue were not fully credible. Accordingly, this court must uphold the ALJ's credibility finding. *See Diaz v. Chater*, 55 F.3d 300, 308 (7th Cir. 1995) ("We have repeatedly stated that an ALJ's credibility determination will not be disturbed unless it is patently wrong."); *Herron v. Shalala*, 19 F.3d 329, 335 (7th Cir. 1994) ("Since the ALJ is in the best position to observe witnesses, we usually do not upset credibility determinations on appeal so long as they find some support in the record and are not patently wrong.").

There is more support in the record for plaintiff's contention that the ALJ should have accounted for his need for frequent bathroom breaks. Plaintiff testified at the administrative hearing that he did not think Figi's would rehire him because he spent so much time in the bathroom. Also, plaintiff told Dr. Gungor that he had up to 10-12 bowel movements a day

when his irritable bowel symptoms were active. The ALJ noted plaintiff's having been diagnosed with irritable bowel syndrome and his statements to Dr. Gungor about his symptoms. In spite of this, the ALJ reasoned later in his decision that plaintiff's irritable bowel syndrome did not impose any work-related limitations because plaintiff "denied symptoms of diarrhea." Although the ALJ did not support his finding with any citation to the record, I infer that the ALJ was referring to a medical note from an emergency room visit when plaintiff complained of abdominal pain but denied having diarrhea. *See* AR 163.

This evidence is not sufficient to support the ALJ's conclusion that plaintiff's irritable bowel symptoms did not impose any limitations on his residual functional capacity. That plaintiff may not have been experiencing diarrhea during one visit to the emergency room is not inconsistent with his allegations of sporadic bouts of severe diarrhea requiring frequent bathroom visits. Because the ALJ did not articulate any other specific reasons for rejecting plaintiff's alleged need for frequent bathroom breaks, this court could remand the case for additional findings on that point.

However, I am not recommending that course of action because the ALJ made other findings that fairly support his overall conclusion that plaintiff's irritable bowel syndrome did not cause limitations that would prevent plaintiff from performing his past work. First, as the ALJ noted, plaintiff testified that he was laid off from Figi's because of a lack of work, not because he spent too much time in the bathroom. Second, the ALJ noted that plaintiff's doctors had ruled out ulcerative colitis or Crohn's Disease, evidence which tends to suggest

that plaintiff's symptoms were not severe.[2] Finally, the ALJ credited the opinion of the state agency consulting physician, who opined that plaintiff could perform the full range of light work on a regular and sustained basis despite his impairments. This evidence supports adequately the ALJ's conclusion that plaintiff's ability to work was not limited by a need for frequent bathroom breaks. Although the ALJ could have been more articulate regarding plaintiff's subjective complaints of bouts of diarrhea, a commonsensical reading of his opinion reveals the path of his reasoning. Accordingly, I see no need to remand the case on this basis.

D. Back Pain

Next, plaintiff contends the ALJ erred in rejecting his complaints of back pain. First, plaintiff contends the ALJ erred by failing to consider his daily activities, precipitating or aggravating factors, use of pain medications and other factors found relevant by the Commissioner for assessing the credibility of subjective complaints. *See* Soc. Sec. Ruling 96-7p; 20 C.F.R. § 405.1529. This contention is frivolous. In addition to noting the absence of objective medical evidence to support the severity of the pain alleged, the ALJ noted that

[2] Ulcerative colitis and Crohn's disease are the two most common forms of inflammatory bowel *disease*, which is more severe than irritable bowel *syndrome*. Unlike inflammatory bowel disease, irritable bowel syndrome does not cause inflammation or changes in bowel tissue and its symptoms are usually mild. (This information can be found by searching for the term "irritable bowel syndrome" at www.mayoclinic.com.)

plaintiff's daily activities were not restricted significantly, he was not receiving any active treatment or therapy for his conditions and was not using prescriptive pain medications, and he had worked at the substantial gainful activity level for several months after he claimed he was disabled. By considering these factors and explaining the weight he gave to them, the ALJ followed properly the Commissioner's procedure for evaluating the credibility of a claimant's subjective complaints.

Furthermore, the ALJ's findings are all adequately supported by the record. Plaintiff completed a daily activities questionnaire on which he reported that his activities included working on his gemstone hobby, writing stories, listening to music, visiting with friends, and helping his mother with snow removal, home repair and yard work. Plaintiff reported that he read, talked on the phone and listened to music on a daily basis. He drove, did yard work and visited friends on a weekly basis. In spite of all of his subjective complaints, plaintiff reported that these activities had not changed much due to his condition except for his need to rest more. This evidence supports the ALJ's conclusion that plaintiff was not as limited by his impairments as he claimed.

Plaintiff argues that the ALJ did not account for plaintiff's need to rest frequently while carrying out his daily activities. In his brief, plaintiff attributes his need for these rest periods to his back pain. *See* Pltf.'s Mem. in Supp., dkt. #9, at 33. However, this contention is inconsistent with his fatigue questionnaire, on which plaintiff indicated that his need to rest was caused by the chronic fatigue he experiences in connection with his

irritable bowel syndrome, not his back pain. *See* AR at 85-87. As noted previously, the ALJ had adequate reasons for finding that plaintiff's complaints of fatigue were not credible. Insofar as plaintiff's alleged need to take breaks between activities was based upon that symptom, the ALJ could reasonably reject it. Furthermore, the ALJ could reasonably conclude that plaintiff's ability to perform work at the substantial gainful level from October 1999 to February 2000 was inconsistent with his claimed need for frequent rest periods.

As for the ALJ's finding regarding medications, plaintiff points out that he takes over-the-counter pain medication as well as medication for his irritable bowel syndrome and anxiety disorder. However, the ALJ could properly find that plaintiff's reliance on over-the-counter medication for pain relief tended to suggest that his pain was not as severe as plaintiff alleged. *Powers v. Apfel*, 207 F.3d 431, 435 (7th Cir. 2000) (not patently wrong for ALJ to consider "the absence of drugs prescribed for severe pain" in assessing credibility of pain complaints).

E. Unemployment Compensation

Finally, plaintiff contends the ALJ erred when he found that plaintiff's disability claim was inconsistent with his application for unemployment compensation. Plaintiff argues that a claimant's application for unemployment benefits should not hurt his credibility because claimants often overestimate their ability to work, seek a job that would accommodate their disability or are desperate financially. Although I agree that a claimant's statement that he

is ready, willing and able to work for the purposes of seeking unemployment compensation is not conclusive evidence that his disability claim is phony, *see*, *e.g.*, *Jernigan v. Sullivan,* 948 F.2d 1070, 1074 (8th Cir. 1991); *Perez v. Secretary of HEW*, 622 F.2d 1, 3 (1st Cir. 1980); *Bartell v. Cohen*, 445 F.2d 80, 82 (7th Cir. 1971) (plaintiff's attempts to find job were "relevant only to her motivation and not to whether she was, in fact, disabled"), I am not convinced that such statements are entitled to no weight in the credibility analysis. With regard to this case, it is notable that although plaintiff has offered global theories for reconciling unemployment compensation applications with disability claims, he does not direct the court to specific evidence in the record that shows that any of these theories apply to him. In any case, it is not necessary to address this issue in detail. Even if this court disregards the ALJ's finding on this point, the ALJ cited other evidence that adequately supports his credibility finding.

In sum, substantial evidence in the record supports the ALJ's conclusion that plaintiff did not suffer from a severe mental impairment and that his subjective complaints of pain, fatigue and other symptoms were not fully credible. Accordingly, this court should affirm the decision of the Commissioner.

RECOMMENDATION

Pursuant to 28 U.S.C. § 636(b)(1)(B), I respectfully recommend that the decision of the Commissioner denying plaintiff Robert E. Schmidt's application for benefits under the Social Security Act be AFFIRMED. Plaintiff's motion for a remand for consideration of new and material evidence pursuant to sentence six of 42 U.S.C. § 405(g) should be DENIED.

Entered this 2nd day of December, 2003.

BY THE COURT:

STEPHEN L. CROCKER
Magistrate Judge