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

HAROLD ANDERSON,

Plaintiff,

v.

JO ANNE B. BARNHART
Commissioner of Social Security,

Defendant.

REPORT AND
RECOMMENDATION

04-C-705-C

REPORT

Plaintiff Harold Anderson's appeals an adverse determination of a decision of the Commissioner of Social Security pursuant to 42 U.S.C. § 405(g). Plaintiff challenges the commissioner's determination that he is not disabled and therefore not entitled to either Disability Insurance Benefits or Supplemental Security Income under sections 216(I) and 223 and 1614(a)(3)(A) of the Social Security Act, codified at 42 U.S.C. §§ 416(I), 423(d) and 1382c (3)(A). On appeal, plaintiff raises a single claim: the administrative law judge (ALJ) who decided his claim at the administrative level erred in rejecting the opinion of one of his treating physicians, Dr. Buss, who stated that plaintiff is unable to work because of limitations imposed by his heart condition.

Because the ALJ articulated sufficient reasons for rejecting Dr. Buss's opinion, I am recommending that the court reject plaintiff's argument and affirm the commissioner's decision.

Legal and Statutory Framework

To be entitled to either disability insurance benefits or supplemental security income payments under the Social Security Act, a claimant must establish that he is under a disability. The Act defines "disability" as 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. § 404.1520. The inquiry at steps four and five requires an assessment of the claimant's "residual functional capacity," which the commissioner has defined as "an

assessment of an individual's ability to do sustained work-related physical and mental activities in a work setting on a regular and continuing basis." Social Security Ruling 96-8p. "A 'regular and continuing basis' means 8 hours a day, for 5 days a week, or an equivalent work schedule." *Id*.

In seeking benefits, the claimant bears the initial burden to prove that a severe impairment prevents him from performing his past relevant work. If he shows this, then the burden shifts to the commissioner to show that the claimant was able to adjust to any 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). At this final step, the ALJ must take into account the individual's residual functional capacity as well as the vocational factors of his age, education and work experience. 20 C.F.R. §§ 404.1520; 404.1560.

FACTS

The following facts are drawn from the administrative record (AR):

I. Procedural History

Plaintiff applied for DIB and SSI on April 20, 1999, alleging that he became disabled on October 1, 1998, as a result of headaches, groin cysts, chest pain, a bad heart and a tailbone (pilonidal) cyst.[1] After the local disability agency denied his claims initially and on

[1] Pilonidal cysts are pockets of skin in the crease of the buttocks near the bottom of the tailbone that either are present at birth or caused by ingrown hairs in the folds of the skin. They may cause discomfort or infection that can result in a painful abscess. Even if treated successfully, they can recur. *See* http://www.mayoclinic.com.

reconsideration, plaintiff requested a hearing before an administrative law judge (ALJ). A hearing was held on February 26, 2002, at which plaintiff testified and was represented by a lawyer. On July 17, 2002, the ALJ issued a decision finding that although plaintiff had severe impairments, these impairments were neither so severe as to be presumptively disabling nor imposed limitations that restricted plaintiff from performing all substantial gainful activity. On July 23, 2004, the Appeals Council denied plaintiff's request for review, making the ALJ's decision the final decision of the commissioner. Plaintiff then filed the instant action for judicial review pursuant to 42 U.S.C. § 405(g).

II. Background and Medical Evidence

Plaintiff was 47 years old on the date of ALJ's decision. His period of eligibility for disability insurance benefits expired on December 31, 1998. He is obese, standing 5' 8" tall and weighing 265 pounds. Plaintiff completed school through the 11th grade and later obtained his GED. Plaintiff's primary past work experience is as a truck driver. According to plaintiff's testimony at the administrative hearing, he stopped his trucking business in 1996 because he had a heart attack, which caused him to have stress, blackouts while driving and problems using his left arm. Plaintiff explained that after that he worked intermittently for other trucking companies, but had to quit because the driving caused his tailbone cyst to flare and he could not do the lifting required by the job.

Medical records show that plaintiff a pilonidal cyst excised in December 1980 and again in July 1984. Plaintiff has a history of high cholesterol and high blood pressure, and

headaches. In 1996, he underwent a neurological evaluation including a CT scan, the results of which generally were negative.

Medical records from after plaintiff's alleged onset date of October 1998 show that in early February 1999, plaintiff saw his treating physician, Dr. Mirza, complaining of body aches, headaches, shortness of breath, intermittent back pain and weakness in his extremities that had been present for the last 3 to 4 weeks. Dr. Mirza prescribed Zestril for high blood pressure and referred plaintiff to Dr. Wallhaus for a cardiac workup.

On the basis of the results of stress testing, Dr. Wallhous gave the opinion that plaintiff might have had a heart attack in early February. He recommended that plaintiff undergo cardiac catheterization. Catheterization showed coronary artery disease and an irreversible anterior wall defect. Plaintiff was started on ACE inhibitor therapy.

At a March 18, 1999 follow-up appointment, Dr. Wallhaus recommended that plaintiff lose weight, quit smoking and begin a cardiac rehabilitation program. He wrote a prescription for Zyban to help plaintiff stop smoking. Dr. Wallhaus noted that plaintiff's blood pressure was under control, plaintiff was not having any heart failure and was on appropriate medications.

On June 17, 1999, plaintiff saw Dr. Wallhaus again and reported that he still experienced episodes of chest discomfort that worsened if he used his arms or engaged in activity. Plaintiff occasionally took nitroglycerin but it had a lag time of several minutes before his chest pain would subside. Plaintiff said he had discontinued the cardiac

rehabilitation program because his pilonidal cyst was bothering him. Plaintiff had not stopped smoking or attempted to obtain the Zyban from Dr. Mirza's office. Dr. Wallhaus noted that plaintiff's report of chest pain was somewhat atypical in that it was described as "sharp" and it recurred upon pressing plaintiff's left sternal border; this caused Dr. Wallhaus to question whether it might be partly costochondritis pain. Dr. Wallhaus reiterated the need for plaintiff to stop smoking and to pursue aggressive secondary management of his cardiac risk factors.

In 1999 , state agency consulting physicians Drs. Chan and Bussan reviewed the record at the request of the state agency and determined that plaintiff could perform work-related activities consistent with the demands of light work in spite his coronary artery disease and obesity.

March 23, 2000 is the next occasion on which plaintiff sought medical care, when he saw Dr. Khan in order to get his medications renewed. Plaintiff reported that he had recently stopped smoking. He denied chest pain, shortness of breath or headaches. Dr. Khan refilled plaintiff's medications for one year.

On July 12, 2000, Plaintiff was seen in the emergency room for complaints of sinus congestion and associated chest pain while coughing for the past three days. Cardiac enzymes and an EKG were negative for any myocardial infarction. Chest x-rays were negative for any acute or active disease. Staff prescribed medicine for sinus and allergy problems and sent plaintiff home.

In March 2001, plaintiff saw Dr. Mirza for another medication refill exam. He complained of chest pain with little activity that lasted 30 minutes and for which he took nitroglycerine. Dr. Mirza refilled plaintiff's prescriptions and told plaintiff that he had to lose weight before he would be a candidate for any surgical treatment for his coronary artery disease.

In July 2001, plaintiff returned to Dr. Mirza complaining of intermittent chest pain, sweating shortness of breath, and occasional headaches. He asked Dr. Mirza to complete the paperwork supporting plaintiff's claim for disability based on his headaches. After reviewing plaintiff's chart, Dr. Mirza declined to support plaintiff's application for disability on that basis, noting that "he has never been evaluated or seen for his headaches as his major complaint." AR 261. Dr. Mirza referred plaintiff for a cardiology consult for his complaints of chest pain.

On July 17, 2001, plaintiff was examined by Dr. Morledge. Plaintiff's blood pressure was 120/88 and his heart rate was 72 with regular rhythm. Dr. Morledge detected no cardiac abnormalities or edema. He recommended that plaintiff return for Doppler testing to determine whether plaintiff had any peripheral vascular disease and if not, for stress testing to assess whether plaintiff's chest pain was exercise-induced angina. AR 225-26.

The following month, plaintiff sought treatment from Dr. Buss, a general practitioner at a different clinic. Plaintiff complained of muscle spasms all over for the last 2 to 3 years that had gotten a little better since he had stopped taking Baycol a week earlier. Plaintiff

told Dr. Buss that he had complained of these spasms frequently to other medical providers but had received no satisfactory answer. Plaintiff told Dr. Buss that ⅓ of his heart was scar tissue. Plaintiff reported shortness of breath with minimal exertion, a pilonidal cyst going "up his spine," and a lump in his left groin that was tender. Plaintiff denied headaches, chest pain or pressure or blurry vision. Dr. Buss reported predominantly normal findings on examination, noting that plaintiff's pulse was 72, his blood pressure was 110/80, his heart rate and rhythm were regular without murmurs, he had 2+ pulses throughout, and his extremities were warm and well perfused with only trace edema. Without having any of plaintiff's past medical records, Dr. Buss concluded that plaintiff had atherosoclerotic heart disease and class IV congestive heart failure[2], as well as a history of hypertension, hyperlipidemia and pilonidal cyst. He reported that plaintiff's heart conditions were stable but might require an increase in medication dosages. He indicated that plaintiff's prognosis was poor given his condition and past history.

On November 13, 2001, Dr. Buss similarly reported that plaintiff was in no acute distress, his blood pressure was 108/70, his pulse was 68, his lungs were clear, his heart rate and rhythm were regular, and his extremities were warm and well perfused with no edema. Dr. Buss also noted at that time that plaintiff's cardiac enzymes were all negative. Plaintiff

[2] Dr. Buss's reference to plaintiff's congestive heart failure as "Class IV" appears to refer to the New York Heart Association's system for classifying patients with heart disease. "Class IV" is the most severe category; patients in this category experience discomfort with any physical activity and should be confined to bed or chair. *See* http://www.americanheart.org.

continued to report shortness of breath with rest and minimal activities of daily living. In addition, plaintiff complained of low back and shoulder pain and left neck pain for the past week. Dr. Buss concluded that plaintiff's coronary artery was stable and that plaintiff should continue his current medications. He prescribed Naprosyn for plaintiff's back pain.

Dr. Buss completed a residual functional capacity (RFC) questionnaire on which he opined that plaintiff had coronary artery disease and congestive heart failure, class IV, with a poor prognosis. He reported that plaintiff's symptoms were chest pain and shortness of breath with activities of daily living. In addition, Dr. Buss indicated plaintiff's impairments had lasted or could be expected to last at least 12 months; that he could sit 8 hours a day but could not lift, carry, walk, or stand at all in an 8-hour work day; and that he was "unable to work." AR 197-99. Dr. Buss did not provide any clinical findings or objective signs where asked to do so on the questionnaire.

III. The ALJ's Decision

The ALJ followed the commissioner's five-step evaluation process in deciding plaintiff's claim. At step one, he found that plaintiff had not engaged in substantial gainful activity since his alleged onset date of October 1, 1998. At step two, he found that the medical evidence established that plaintiff has the following impairments: a history of coronary artery disease with status-post myocardial infarction and some residual damage to the heart, a history of a pilonidal cyst, hypertension and elevated cholesterol (both controlled with medication), and obesity. At step three, the ALJ found that none of plaintiff's

impairments, either singly or in combination, met or medically equaled any impairment that the commissioner has found to be presumptively disabling in Appendix 1, Subpart P, Regulations No. 4.

At step four, the ALJ found that plaintiff retained the residual functional capacity for light work. In reaching this conclusion, the ALJ indicated that he was adopting the opinions of the state agency physicians because they were consistent with the medical evidence, which showed that plaintiff's heart condition had been managed conservatively without surgery or angioplasty, that plaintiff's doctors described his condition as "stable," that plaintiff had not had any ongoing treatment by a cardiologist, and that plaintiff had not complied with his doctors' recommendations to lose weight and to undertake cardiac rehabilitation and plaintiff had not taken a stress test as recommended by Dr. Morledge. The ALJ noted that although plaintiff had alleged numerous other complaints including various aches and pains in his back, shoulders and arms, an inability to use his hands and the pilonidal cyst which plaintiff described at the hearing as "paralyzing," these complaints were either mentioned only briefly or not at all in the medical records. The ALJ considered plaintiff's claim that his health care was limited by a lack of insurance and finances but deemed this an insufficient explanation for the inconsistency between the number and severity of plaintiff's alleged complaints and the medical records, which not only revealed infrequent medical treatment but also established that even when plaintiff *did* obtain treatment, he did *not* report the various complaints he had made at the hearing.

The ALJ rejected the residual functional capacity questionnaire completed by Dr. Buss for several reasons: 1) plaintiff had seen Dr. Buss only infrequently; 2) Dr. Buss's description of plaintiff's cardiac status as "Class IV" was inconsistent with his treatment notes, which described plaintiff's condition as "stable"; 3) Dr. Buss's conclusion that plaintiff could perform no work was inconsistent with Dr. Morledge's recommendation for treadmill testing; and 4) Dr. Buss failed to support his opinion with any clinical findings or signs.

The ALJ found at step four that plaintiff was unable to perform his past relevant work as a truck driver. At step five, the ALJ applied the Medical-Vocational guidelines found at Subpart P, Appendix 2 (a.k.a. "the grids") and concluded that given plaintiff's age, education and work experience and residual functional capacity for a full range of sedentary and light work, he was not disabled.

ANALYSIS

I. Standard of Review

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. Thus, where conflicting evidence allows reasonable minds to differ as to whether a claimant is disabled, the responsibility for that decision falls on the commissioner. *Edwards v. Sullivan*, 985 F.2d 334, 336 (7th Cir. 1993). 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).

II. The ALJ Properly Discounted the Opinion of Dr. Buss

Plaintiff's sole claim is that the ALJ erred by failing to give controlling weight to the opinion of Dr. Buss, who was plaintiff's treating physician and therefore "in the best position to evaluate the claimant." However, a treating physician's opinion is entitled to controlling weight only if it is well supported and "not inconsistent with the other substantial evidence in the case record." 20 C.F.R. §§ 404.1527(d)(2); 416.927(d)(2); *Gudgel v. Barnhart*, 345 F.3d 467, 470 (7th Cir. 2003). As the ALJ explained, Dr. Buss's residual functional capacity assessment was neither.

Dr. Buss did not support his opinion with any clinical findings; in fact, his unremarkable physical examination and conclusion that plaintiff's coronary artery disease

was "stable" were inconsistent with the severe limitations he endorsed. In addition, as the ALJ noted, Dr. Buss had seen plaintiff on only two occasions before offering his opinion that plaintiff was unable to work; indeed, it is not clear whether Dr. Buss even possessed all of plaintiff's medical records when opining on the severity of plaintiff's condition. Finally, the ALJ noted that Dr. Buss's opinion was inconsistent with the opinion of a cardiologist who had recommended treadmill testing. All of these were good reasons, supported by evidence in the record, for the ALJ to reject Dr. Buss's opinion in favor of those of the state agency physicians.

Plaintiff also argues that the ALJ should have consulted an independent examiner to help clarify what the ALJ described were "serious questions" about Dr. Buss's questionnaire. This argument is equally unpersuasive. I agree with the commissioner that a common-sense reading of the ALJ's opinion reveals that this comment was an expression of skepticism toward the accuracy and credibility of Dr. Buss's opinion. The record contained ample evidence to allow the ALJ to evaluate the credibility of Dr. Buss's report and plaintiff's claim that he was disabled. *Luna v. Shalala*, 22 F.3d 687, 692 (7th Cir. 1994) (court "generally respects the ALJ's reasoned judgment" regarding how much evidence needed to make finding about disability).

In sum, there is no merit to plaintiff's claim that the ALJ erred in rejecting the opinion of Dr. Buss.

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RECOMMENDATION

Pursuant to 28 U.S.C. § 636(b)(1)(B), I respectfully recommend that the decision of the Commissioner denying plaintiff Harold Anderson's applications for disability insurance benefits and supplemental security income be AFFIRMED.

Entered this 14th day of October, 2005.

BY THE COURT:
/s/
STEPHEN L. CROCKER
Magistrate Judge

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WISCONSIN
120 N. Henry Street, Rm. 540
Post Office Box 591
Madison, Wisconsin 53701

Chambers of
STEPHEN L. CROCKER
U.S. Magistrate Judge

Telephone
608-264-5153

October 14, 2005

Richard D. Humphrey
Assistant United States Attorney
P.O. Box 1585
Madison, WI 53701-1585

Michael Fitzpatrick Law Office, S.C.
P.O. Box 170850
Whitefish Bay, WI 53217

Re: Anderson v. Barnhart
Case No. 04-C-705-C

Dear Counsel:

The attached Report and Recommendation has been filed with the court by the United States Magistrate Judge.

The court will delay consideration of the Report in order to give the parties an opportunity to comment on the magistrate judge's recommendations.

In accordance with the provisions set forth in the memorandum of the Clerk of Court for this district which is also enclosed, objections to any portion of the report may be raised by either party on or before November 4, 2005, by filing a memorandum with the court with a copy to opposing counsel.

If no memorandum is received by November 4, 2005, the court will proceed to consider the magistrate judge's Report and Recommendation.

Sincerely,

Connie A. Korth
Secretary to Magistrate Judge Crocker

Enclosures
cc: Honorable Barbara B. Crabb, District Judge