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

JOHN KASBERGER,

Plaintiff,

v.

JO ANNE B. BARNHART,
Commissioner of Social Security,

Defendant.

REPORT AND
RECOMMENDATION

05-C-638-C

REPORT

Plaintiff John Kasberger has filed this action for judicial review of a final decision of the Commissioner of Social Security pursuant to 42 U.S.C. § 405(g). Plaintiff suffers from social phobia and filed an application for federal disability benefits, claiming he could not work. The commissioner determined that plaintiff is able to perform a limited range of unskilled jobs in the regional economy and therefore is not entitled to supplemental security income under § 1614(a)(3)(A) Social Security Act, codified at 42 U.S.C. § 1382c(3)(A). Plaintiff contends that substantial evidence fails to support this decision because the administrative law judge who decided the claim at the administrative level failed to give legally sound reasons for rejecting evidence supporting plaintiff's claim.

This court should reject plaintiff's arguments and affirm the commissioner. The ALJ considered all of the evidence in the record, including that favoring plaintiff, and she

explained in detail why she concluded that plaintiff was not disabled. Plaintiff's arguments essentially challenge the manner in which the ALJ weighed the evidence, but this is not a ground to overturn an ALJ's decision that otherwise is supported by substantial evidence in the record.

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)©).

The commissioner has promulgated regulations setting forth the following five-step sequential inquiry to determine whether a claimant is disabled:

(1) Is the claimant currently employed?

(2) Does the claimant have a severe impairment?

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

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

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

See 20 C.F.R. §§ 404.1520; 416.920. At step three, the commissioner considers the medical evidence to determine whether plaintiff has an impairment that meets or is equal in severity to the criteria of numerous impairments, known as the "listings," that the commissioner has determined are presumptively disabling. A mental impairment generally will meet a listing if the impairment produces a "marked" or greater degree of limitation in two or more of the following four broad categories: activities of daily living; social functioning; concentration, persistence or pace; and episodes of decompensation. 20 C.F.R. § 416.920a©); *See generally* 20 C.F.R., Pt. 404, Subpt. P, App. 1, 12.00 (the listings for mental disorders).)

If the claimant suffers from a severe impairment that is not presumptively disabling, then the commissioner considers the record as a whole to determine the claimant's "residual functional capacity," an assessment of the impact the claimant's impairments have on his ability to work full time. In cases involving mental impairments, this assessment considers the claimant's abilities to understand, carry out, and remember instructions; use judgment in making work-related decisions; respond appropriately to supervision, co-workers and work situations; and deal with changes in a routine work setting. Soc. Sec. Ruling 96-8p.

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, then the burden shifts to the commissioner to show that the claimant 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).

I have drawn the following facts from the administrative record ("AR"):

FACTS

I. Background

At the time the ALJ decided this claim, plaintiff was 22 years old. Plaintiff has struggled since childhood with depression, attention deficit hyperactivity disorder and social anxiety. Plaintiff attended special education classes at school through the eighth grade, at which time he left school and was home schooled by his mother. He did not earn a high school diploma. In late 2002, he began working towards obtaining his General Equivalency Diploma, completing all but the math and writing sections.

II. Medical Evidence

Plaintiff began seeing Dr. Howard Spegman, a general practitioner, in October 1996. In March 1998, plaintiff was taking Ritalin and Clonidine; Dr. Spegman added Trazadone for plaintiff's complaints of insomnia. Plaintiff was not seen for any mental complaints until about one year later, when plaintiff reported being depressed and having problems with his father. Plaintiff reported at that time that he had stopped taking the Trazadone. Dr. Spegman encouraged plaintiff to resume taking it. AR 239.

Plaintiff was not seen again for mental complaints until July 2001. Plaintiff was working full time for a tree service. Plaintiff reported that he raced motorcycles and that he felt sick and nervous right before racing. Dr. Spegman prescribed Inderal to be taken a half hour before races. AR 234.

On December 3, 2001, plaintiff saw Dr. Spegman about his social anxiety. Plaintiff reported that he had quit his job at a tree service because of verbal abuse, and had not worked since. He had decided against obtaining his GED and was "really not doing much at this point." AR 233. Plaintiff told Dr. Spegman that he was uncomfortable being around a lot of other people. Dr. Spegman diagnosed social anxiety disorder and prescribed Paxil. AR 233.

On December 18, 2001, plaintiff reported feeling more nervous and sweating at times on the Paxil. Dr. Spegman discontinued the Paxil and prescribed Effexor. However, on February 25, 2002, plaintiff reported that he had stopped taking the Effexor, indicating that "he does not want any medicines whatsoever." AR 233. Plaintiff described himself as a loner, indicating that he spent a lot of time with his mom and enjoyed hunting and fishing. He denied significant depression. *Id*. Dr. Spegman did not see plaintiff for mental complaints until more than a year later.

On February 21, 2003, when plaintiff was 20 years old, he filed an application for supplemental security income, alleging that he was unable to work since December 3, 2001 due to a social anxiety disorder and attention deficit hyperactivity disorder. At the request

of the social security office, on June 10, 2003, Harlan Heinz, Ph.D., performed a consultative evaluation of plaintiff. AR 201-206. Plaintiff reported that his most recent work was with a tree service cutting trees and driving a truck. He said while working there, his boss yelled at him frequently. Plaintiff reported that he had begun working towards his GED and had received good grades; however, plaintiff still had not finished his course work. Plaintiff was taking no medications and receiving no counseling.

On mental status exam, plaintiff was well-groomed and displayed a cooperative attitude with no evidence of malingering. Plaintiff appeared nervous, consistent with his self-report. His speech generally was normal and his thought content was logical, but he spoke softly and was somewhat difficult to understand. Plaintiff had some paranoid thoughts, reporting that people talked about him. He had fair memory, adequate concentration and attention, and was able to perform a three-step command. Dr. Heinz estimated plaintiff's intelligence to be average to low average. Dr. Heinz noted that although plaintiff had been diagnosed with ADHD as a child, no symptoms of that illness were present during the exam.

Plaintiff reported that his biggest problem was that he never left his room. He said he read about five to six hours a day and watched television four to six hours a day. He also performed chores around the house including cutting grass, feeding the dogs, cleaning, doing laundry, grocery shopping with his mother, vacuuming and dusting, and some meal preparation. Other interests included fishing, hiking, racing his dirt bike and exploring

abandoned buildings. According to Dr. Heinz, plaintiff was "obviously an extremely anxious young man and has been most of his life."

Dr. Heinz found that plaintiff had social phobia with features of obsessive-compulsive disorder and a panic disorder with agoraphobia. He indicated that plaintiff would have a poor ability to relate to supervisors or coworkers, poor ability to cope with stress and change and an average ability to maintain attention, concentration and pace.

On June 23, 2003, state agency consultant Jean Warrior, Ph.D., reviewed and signed a Psychiatric Review Technique Form (PRTF) and a Mental Residual Functional Capacity (MRFC) assessment of plaintiff. (It appears that the form was filled out beforehand by the disability examiner from the local disability agency. The SSA's internal rules allow this. *SSA Program Operations Manual System* (POMS), DI 24505.025 (disability examiner may assist in preparing forms but psychological consultant "must review and sign the document to attest that it is complete and that he or she is responsible for its content, including the findings of fact and any discussion of supporting evidence").) Under the "A" criteria of listed mental disorders, Dr. Warrior reported that plaintiff suffered from severe anxiety disorders, namely, social phobia with features of obsessive compulsive disorder and a panic disorder with agoraphobia. With respect to the "B" criteria, she found that plaintiff had mild restrictions of activities of daily living, moderate difficulties in maintaining social functioning, no difficulties in maintaining concentration, persistence, or pace and no episodes of decompensation. On the MRFC form, Dr. Warrior indicated on the "Summary

Conclusions" portion of the form that plaintiff had no marked limitations, but had moderate limitations in his ability to perform various mental work-related tasks. In the section of the form requiring the psychological consultant to express the claimant's residual functional capacity in narrative fashion, Dr. Warrior indicated "See EWS," referring presumably to the case development worksheet prepared by the disability examiner. On that sheet, the disability examiner had indicated that plaintiff's ability to relate to others was his most severe limitation, but that there were "many low stress, routine, unskilled jobs [with] limited public or co-worker contact that [claimant] would be able to perform." AR 74.

Plaintiff saw Dr. Spegman on July 3, 2003. After reviewing Dr. Heinz's report and talking to plaintiff and his mother, Dr. Spegman recommended that plaintiff try Paxil CR, explaining to plaintiff that "if he could possibly benefit from this that he can get into his bike mechanics and he can make a life for himself." AR 230. However, on August 6, 2003, plaintiff reported that he had not taken the samples Dr. Spegman had given him, indicating that he was not going to take any medicines that "mess him up." AR 230. Dr. Spegman encouraged plaintiff to reconsider his decision.

That same day, Dr. Spegman dictated a letter stating that plaintiff suffered from a social anxiety disorder with features of agoraphobia. He reported that plaintiff's answers on a questionnaire indicated moderate to marked depression. Dr. Spegman reported that plaintiff had difficulty completing tasks and living independently, noting that he lived with his parents. Dr. Spegman opined that Paxil CR would be an "excellent" medication for plaintiff's conditions; however, plaintiff refused to take it. AR 229.

On August 26, 2003, Dr. Spegman declined to complete a mental impairment questionnaire for plaintiff. He advised plaintiff's attorney that he was a family physician and lacked the proper expertise to complete the form; he recommended that Dr. Heinz complete the form. Dr. Spegman found it unfortunate that plaintiff had refused to take Paxil, indicating that the medication possibly would have reduced plaintiff's social phobia and panic attacks. Apart from counseling and psychiatric intervention, he was aware of no other way to help plaintiff. AR 227.

On October 23, 2003, in connection with plaintiff's request for reconsideration of the initial denial of his disability application, state agency consultant Roger Rattan, Ph. D., confirmed Dr. Warrior's PRTF and mental RFC as written. Dr. Rattan found from the record that plaintiff "can tolerate interaction with others if he is not intimidated directly or feeling strong anticipatory anxiety"; from this, Dr. Rattan concluded that plaintiff could perform "routine low stress work on a regular basis." AR 69.

On February 2, 2004, plaintiff's parents asked Dr. Spegman, to complete a form for their insurance company stating that plaintiff was disabled and dependent on them and therefore still covered by their insurance. Plaintiff's parents reported that plaintiff engaged in obsessive-compulsive behaviors and rarely left his bedroom. After speaking with the Kasbergers, Dr. Spegman completed the form, indicating that plaintiff was disabled. AR 226.

Plaintiff saw Dr. Spegman on August 26, 2004 and reported that his panic attacks were worsening; any time he went outside, he said, his heart raced and he started to sweat. Plaintiff still continued to spend most of the day at home working on his computer and had given up motorcycle racing. Plaintiff said he was considering trying medication but remained very concerned about taking a pill. Plaintiff revealed that his concern stemmed from a childhood incident when he was kicked in the groin and lost a testicle; plaintiff attributed his inability to defend himself from that injury to the Ritalin he was taking at the time. Dr. Spegman prescribed Zoloft and Xanax. AR 283-84.

On September 17, 2004, plaintiff reported that he had stopped taking Zoloft after 10 days because of side effects, including paranoia and increased insomnia, and the Xanax because it was not very helpful. He reported feeling better since he stopped the medications. Dr. Spegman reported that plaintiff now had tried Paxil, Zoloft, Clonidine, Bu-Spar, Trazodone, Effexor and Xanax, "all with bad results." Dr. Spegman prescribed Lorazepam to be taken as needed when plaintiff had a panic attack. AR 283.

III. Hearing Testimony

At the administrative hearing on his disability claim, plaintiff testified that he was working about four hours a week maintaining the grounds at the Palms, a supper club located a quarter mile from his home. Plaintiff worked alone, mowing the lawn, trimming weeds and raking. He testified he could not work full time because he "couldn't take" being

around people. For example, plaintiff said, if he went to the store he got nervous, had trouble breathing, couldn't decide what to buy and just wanted to get back home. These panic attacks could last an hour or more after he got away from the cause and were not helped by medication. Sometimes being around just one person made him uncomfortable but mostly it was crowds and busy places. AR 297. He also testified that he had to have things a particular way and if they weren't, he got aggravated and nervous. AR 303-04.

Plaintiff testified that when he wasn't working, he mostly stayed in his room watching television or looking up things on the computer, such as places to go hiking with his mom. He did his own laundry, went grocery shopping with his mom and helped out around the house when asked. He said his only other activity at the time was photography. He said he left the house about once a week and when he did, it was with his mom.

Plaintiff's mother testified that plaintiff had always had problems interacting with others. She noticed that it worsened in eighth grade and had continued to worsen since, with plaintiff becoming more and more reclusive. AR 314. She said plaintiff was afraid to leave home, be around people or have germs touch his skin. AR 310. He was particular about what he ate and had problems tolerating noise. She testified that plaintiff went out of the home accompanied by her about once a week. She said plaintiff had daily panic attacks that ranged from mild to severe and could be caused by the dogs barking or plaintiff's nephew visiting. During such an attack, plaintiff became withdrawn, started to sweat and sometimes shake, had trouble breathing and felt disoriented and fearful. Plaintiff's mother

testified that plaintiff was able to concentrate on things he enjoyed doing for "a while" but he often did not finish projects or he did them over a period of days. AR 312-13.

Dr. Michael Lace, a clinical psychologist, testified at the hearing as a neutral medical expert. Dr. Lace concluded from the record and the testimony that plaintiff suffered from social phobia, panic disorder with agoraphobia, obsessive compulsive disorder and attention deficit hyperactivity disorder. Evaluating plaintiff's functional limitations under the paragraph "B" criteria of the listings, Dr. Lace opined that plaintiff had mild limitation in his activities of daily living; marked limitation in his social functioning; marked limitations in concentration, persistence and pace; and no episodes of decompensation. Dr. Lace testified that his conclusions were based primarily on Dr. Spegman's clinical records and from the testimony of plaintiff and his mother regarding how rarely plaintiff left the house. Dr. Lace further testified that if plaintiff was to work, he should have a low stress job; limited contact with the general public; brief and superficial contact with supervisors; an "extremely" predictable schedule with no surprises that might trigger a panic attack; and short breaks every half hour. Dr. Lace predicted that plaintiff would have attendance problems unless he worked at home or in a similar, highly-supportive setting.

Paul Maulucci testified as a vocational expert. The ALJ asked Maulucci whether there was work available for a hypothetical individual of plaintiff's age, education and work experience who was limited to low stress work requiring only minimal changes in work tasks, processes or schedule; minimal industrial standards for production and pace; the ability to

work with no more than two other people; no public contact; and which allowed the individual to "withdraw from doing the task at hand momentarily just to collect one's self and then return to the task at hand" on an as-needed basis. AR 319-20. Maulucci testified that such an individual could perform plaintiff's past work as a groundskeeper, Christmas tree farm worker and tree surgeon helper. In addition, Maulucci said, such an individual could perform the jobs of kitchen helper or equipment vehicle cleaner.

IV. ALJ's Decision

The ALJ followed the commissioner's five-step process for evaluating disability claims. At step one, she found that plaintiff had not engaged in substantial gainful activity after his alleged onset date. At step two, she found that plaintiff has the following severe impairments: social phobia disorder, an obsessive compulsive disorder, a panic disorder with agoraphobia and an attention deficit hyperactivity disorder.

At step three, the ALJ found that plaintiff's impairments were not severe enough to meet the listings because they did not result in "marked" limitation in two or more of the relevant areas of function. Although the ALJ found that plaintiff had marked difficulties in social functioning, she found that he had only moderate difficulties in maintaining concentration, persistence or pace and no episodes of decompensation. In reaching this conclusion, the ALJ explained why she disagreed with Dr. Lace that plaintiff had "marked" limitation in concentration, persistence or pace:

> The claimant testified that he is able to go to the grocery store with his mother and take a message from a phone call. He works part-time as a groundskeeper at a local restaurant. He drives a lawn mower and paints. His concentration is adequate for driving, cooking, cleaning and doing the laundry. His hobbies include working on the computer, racing motorcycles, hiking and photography. Mr. Kasberger's favorite past-time is to take pictures of old mines and old ruins. He also enjoys tying flies for fly fishing. He reported that sometimes he has problems concentrating. The claimant finished the 8th grade and he is close to finishing his GED. During his testimony, he reported that he helped his family roof and re-side the house.
>
> The State Agency Medical Consultants opined that the objective medical evidence and medical history demonstrated no problems with maintaining concentration, persistence and pace and Dr. Lace opined that the claimant had marked limitation in maintaining concentration, persistence and pace. The claimant's daily activities and hobbies are fairly sophisticated and involve a good ability to maintain concentration, persistence and pace. However, his failure to follow-through with his education and his ongoing anxiety reduces his ability to maintain concentration.
>
> The undersigned concludes this evidence demonstrates the claimant experiences moderate difficulties in maintaining concentration, persistence or pace. The undersigned gives no weight to the medical expert's opinion that the claimant has marked limitation in this domain, because it is inconsistent with his wide range of daily activities and sophisticated hobbies.

AR 22-23.

The ALJ then assessed plaintiff's residual functional capacity, concluding that plaintiff could perform low stress work tasks at all exertional levels with minimal industry standards

for maintaining pace and persistence, minimal changes in the job tasks process and allowing for short breaks to compose himself, no public contact and only brief and superficial contact with others such as working alone or with one or two other people. In making this determination, the ALJ considered the record as a whole, including both plaintiff's and his mother's testimony regarding his limitations. The ALJ found plaintiff and his mother credible insofar as their testimony indicated that plaintiff had some degree of limitation. However, she rejected plaintiff's claim that he was incapable of all work activity, finding that it was inconsistent with his failure to follow his doctor's advice to take medication, his limited course of treatment for his social phobia, his wide range of daily activities and the limited objective medical evidence. The ALJ also noted that her residual functional capacity determination was consistent with the opinion of Dr. Heinz, who indicated that plaintiff could concentrate adequately and would have an average pace of work, but would not cope well with stress and changes and would relate poorly to supervisors and coworkers. The ALJ also pointed out that the limitations endorsed by Dr. Heinz were consistent with those found by the state agency consultants at the previous determination levels.

Although the vocational expert testified that a person of plaintiff's age, education and work experience with the residual functional capacity found by the ALJ would be able to perform plaintiff's past relevant work, the ALJ determined that plaintiff had met his burden at step four because he had not performed any of his past jobs at a level constituting substantial gainful activity. Accordingly, the ALJ proceeded to step five to determine

whether plaintiff nonetheless could perform a significant number of jobs existing in the regional economy. Relying on Maulucci's testimony, the ALJ determined that plaintiff could perform the following jobs: groundskeeper (3,000 jobs in Wisconsin); tree farm worker or tree service worker (5,000 jobs); vehicle cleaner (6,000 jobs); and kitchen helper (7,500 jobs). Accordingly, the ALJ concluded that plaintiff was not disabled.

The ALJ's decision became the final decision of the commissioner when the Appeals Council denied plaintiff's request for review.

ANALYSIS

I. Standard of Review

In a social security appeal brought under 42 U.S.C. § 405(g), this court does not re-evaluate 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 an 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).

As for credibility determinations, an ALJ is best positioned to determine a witness's truthfulness, and courts may not overturn an ALJ's credibility determination unless it is "patently wrong." *Briscoe ex rel. Taylor v. Barnhart*, 425 F.3d 345, 354 (7th Cir. 2004). A court should affirm an ALJ's credibility finding if the ALJ gives specific reasons for the finding that are supported by the record. *Brindisi ex rel. Brindisi v. Barnhart*, 315 F.3d 783, 787 (7th Cir. 2003).

II. Dr. Lace

Plaintiff argues that the ALJ erred in rejecting Dr. Lace's opinion that plaintiff had "marked" limitations in concentration, persistence or pace and in her corresponding conclusion that plaintiff's condition was not severe enough to meet the listings because he did not have "marked" or higher restrictions in two or more of the relevant functional categories. Citing *Wilder v. Chater*, 64 F.3d 335 (7th Cir. 1995), plaintiff first contends that

the ALJ committed an error of law, arguing that under *Wilder*, the opinions of impartial medical experts who testify at administrative hearings are to be given "significant weight." However, in *Wilder*, the court criticized the ALJ for rejecting the opinion of a neutral medical expert not because the expert was impartial, but because the expert's testimony was the *only* medical evidence in the case regarding Wilder's onset date and the reasons cited by the ALJ for rejecting it were not supported by the record but were "rank conjecture." *Id*. at 337-38. Nothing in *Wilder,* the other cases cited by plaintiff or the social security regulations supports plaintiff's contention that the opinions of neutral medical experts who testify at administrative hearings must be weighed differently than other medical opinions in the record. *See* 20 C.F.R. § 416.927 (describing how commissioner weighs medical opinions).

Even so, argues plaintiff, the ALJ should have credited Dr. Lace's opinion because he was the only doctor who considered *all* of the evidence in the record. Plaintiff points out that Dr. Lace reviewed plaintiff's medical records from 2003-2004 and that these records were not available to Dr. Heinz or to the state agency consultants when they assessed plaintiff's condition in mid-2003. However, plaintiff fails to identify anything in those later records suggesting that plaintiff has marked as opposed to moderate limitations in concentration. Plaintiff simply argues that Dr. Lace's opinion is more persuasive because he reviewed all the available medical records and leaves it at that. Absent some explanation from plaintiff *why* these additional records undermine the ALJ's conclusion that plaintiff had only moderate limitations in concentration, this "argument" is merely a premise devoid of

any rationale. As such, it fails to support plaintiff's contention that the ALJ erred in rejecting Dr. Lace's opinion.

Plaintiff accuses the ALJ of "playing doctor" by relying solely on plaintiff's daily activities as a basis for discounting Dr. Lace's opinion. The ALJ's decision establishes that she did no such thing. The ALJ was confronted with conflicting medical evidence regarding the degree to which plaintiff's impairments limited his abilities of concentration, persistence or pace: the opinions of the state agency consultants, who thought plaintiff had no limitations in this area; and the opinion of Dr. Lace, who thought plaintiff had marked limitations. To resolve this conflict, the ALJ considered the evidence in the record bearing on how plaintiff functioned on a daily basis, and concluded that plaintiff's concentration abilities lay somewhere in the middle, in the "moderate" range. The ALJ did not "play doctor" or abuse her power as the ultimate decision-maker but properly exercised her duty to resolve conflicts in the evidence. *See Dixon v. Massanari*, 270 F.3d 1171, 1178 (7th Cir. 2001) ("When treating and consulting physicians present conflicting evidence, the ALJ may decide whom to believe so long as substantial evidence supports that decision").

Plaintiff next argues that his limited activities are inconsistent with "a finding of his being able to engage in activities with a high degree of concentration, persistence and pace." Pt.'s Br., dkt. 7, at 55. However, the ALJ never found that plaintiff had a "high degree" of concentration, persistence and pace. The ALJ merely pointed out that plaintiff was able to engage in various activities that indicated that he was not "markedly" limited in his ability

to concentrate, including working part-time as a groundskeeper, performing chores around the house, working on the computer, taking photographs, tying flies for fly-fishing and successfully completing GED courses. Plaintiff attacks this paragraph of the ALJ's decision line by line, arguing that in some instances the ALJ misstated the record and in others, overstated plaintiff's abilities.

Having considered these arguments, I am persuaded that the ALJ did not commit any material factual errors and that her reasoning is sound. It was not a stretch for the ALJ to describe plaintiff's activities as "fairly sophisticated" or to conclude that they showed plaintiff was less limited in his concentration, persistence and pace than Dr. Lace found. Plaintiff's arguments to the contrary are little more than a disagreement about how the ALJ weighed the evidence. As noted above, principles of administrative review limit this court to determining whether the ALJ's conclusions are reasonably supported by the evidence; they preclude this court from deciding the disability determination anew or deciding how the evidence should be weighed. Because the ALJ adequately and thoroughly discussed the evidence and gave sound reasons for her conclusion that plaintiff is less limited in his ability to concentrate, attend and persist than found by Dr. Lace, this court must affirm the ALJ's determination on this point.

III. Residual Functional Capacity/Hypothetical

Plaintiff argues that the ALJ's residual functional capacity assessment and corresponding hypothetical to the vocational expert failed adequately to account for all of the "moderate" limitations identified by the state agency consultants on the mental residual functional capacity assessment form. *Young v. Barnhart*, 362 F.3d 995, 1005 (7th Cir. 2004) (vocational expert's conclusion that claimant can adjust to other work cannot stand unless expert is presented with hypothetical that includes all limitations supported by the record). Plaintiff contends that the ALJ should have incorporated the state agency consultants' findings that plaintiff would have moderate limitations in his abilities to: maintain regular attendance and punctuality; complete a normal workday or workweek without interruptions from psychologically-based symptoms; and perform at a consistent pace without an unreasonable number and length of rest periods.

But as the commissioner points out, the state agency consultants opined that, in spite of the moderate limitations endorsed on the "summary conclusions" portion of the form, plaintiff still could perform routine low stress work requiring only limited contact with others. *See* AR 69, 74. Thus, the ALJ was correct when she stated that her residual functional capacity assessment was consistent with that of the state agency consultants. AR 26. *See Johansen v. Barnhart*, 314 F.3d 283, 288 (7th Cir. 2002) (when medical expert translates findings on "B" criteria of listings to specific residual functional capacity assessment, ALJ may reasonably rely on that opinion in formulating hypothetical question).

The ALJ noted that her RFC assessment was supported by Dr. Heinz's finding that plaintiff had an average ability to maintain pace at work but would not cope well with stress and changes or frequent interaction with others. Plaintiff does not dispute that Dr. Heinz's report supports the ALJ's RFC assessment. Instead, he argues that the ALJ erred in relying on Dr. Heinz's report because Dr. Heinz did not have available to him the most recent clinical notes from Dr. Spegman. Again, however, plaintiff fails to identify what it is about those records that undermines Dr. Heinz's conclusions about plaintiff's work abilities. If anything, Dr. Spegman's later records actually *support* the ALJ's reliance on Dr. Heinz's report insofar as Dr. Spegman indicated that Dr. Heinz was more qualified to provide an assessment of plaintiff's mental abilities.

Dr. Spegman did opine that plaintiff was disabled, but as the ALJ noted, he did so at the request of plaintiff's parents so that plaintiff could be covered by their health insurance. As the ALJ pointed out, insurance determinations are not the same as Social Security disability determinations; moreover, Dr. Spegman acknowledged that he was not a specialist in mental impairments. These were adequate reasons to reject Dr. Spegman's disability opinion in favor of the findings made by Dr. Heinz, the mental health specialist who evaluated plaintiff specifically for the purposes of his disability application.

Overall, the record reasonably supports the ALJ's determination that plaintiff retained the residual functional capacity to perform a limited range of unskilled jobs. Where, as here, the ALJ considers all of the evidence of record, describes it accurately and provides a logical

explanation why she credited some pieces of evidence and rejected others, this court has no basis for reversing the ALJ's decision.

IV. Credibility

Finally, plaintiff argues that the ALJ's adverse credibility assessment cannot stand insofar as it was based upon plaintiff's failure to take medication for his social phobia. Plaintiff argues that under the commissioner's non-compliance regulation, the ALJ could not hold his noncompliance with treatment against him without first making specific findings that the medication would restore plaintiff's ability to work and that plaintiff did not have a "justifiable" excuse for not taking it. 20 C.F.R. § 416.930 ("In order to get benefits, you must follow treatment prescribed by your physician if this treatment can restore your ability to work"; failure to do so without good reason will result in denial of benefits).

True, the ALJ did not expressly refer to the regulation or purport to make specific findings in accordance with it; nonetheless, her decision reflects that she applied the regulation properly. There is no dispute that plaintiff has refused to take medication except Lorazepam, which he takes only on an as-needed basis. Plaintiff argues that his desire to avoid unpleasant side effects is a justifiable reason for this refusal, pointing out that Dr. Spegman indicated in one record that plaintiff had tried a number of medications unsuccessfully because of side effects. However, plaintiff ignores the fact that there were some medications that he never tried because of "feared," not actual, side effects. In

particular, plaintiff refused to try Paxil CR even though Dr. Spegman told him that he thought plaintiff's condition would improve if he took the medication. Moreover, as the ALJ noted, plaintiff's "side effects" claim is undermined by his testimony that he experiences no side effects from the Lorazepam. This evidence reasonably supports the ALJ's determination that plaintiff's use (or in this case, non-use) of medication was a factor suggesting that his claim of total disability was not credible.

Moreover, the ALJ cited other reasons besides plaintiff's failure to comply with recommended treatment that are sufficient to support her credibility determination. She noted that plaintiff saw Dr. Spegman only infrequently for his social phobia problems and had not participated in any counseling or psychotherapy to address those problems. In addition, the ALJ noted that plaintiff had a spotty work history and he had not sought out work within his limitations since his alleged onset date. The ALJ pointed out that the fact that plaintiff was able to work as a handyman and groundskeeper for a local restaurant indicated that he could work outside the home and have at least some contact with people. She also noted that plaintiff was able to get along with counselors when working towards his GED. All of this evidence reasonably supports the ALJ's determination that there were at least some jobs that plaintiff could perform and that his allegations to the contrary were not entirely credible.

RECOMMENDATION

Pursuant to 28 U.S.C. § 636(b)(1)(B), I respectfully recommend that the decision of the commissioner denying plaintiff John Kasberger's application for supplemental security income benefits be affirmed.

Entered this 22nd day of June, 2006.

BY THE COURT:

/s/

STEPHEN L. CROCKER
Magistrate Judge

June 22, 2006

Dana W. Duncan
Schmidt, Grace & Duncan
P.O. Box 994
Wisconsin Rapids, WI 54495-0994

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

Re: Kasberger v. Barnhart
Case No. 05-C-638-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 July 14, 2006, by filing a memorandum with the court with a copy to opposing counsel.

If no memorandum is received by July 14, 2006, the court will proceed to consider the magistrate judge's Report and Recommendation.

Sincerely,

/s/

Connie A. Korth
Secretary to Magistrate Judge Crocker

Enclosures
cc: Honorable Barbara B. Crabb, District Judge