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

DAVID T. BENNETT,

Plaintiff,

v.

JO ANNE B. BARNHART,
Commissioner of Social Security,

Defendant.

REPORT AND
RECOMMENDATION

06-C-0027-C

REPORT

This is an appeal of an adverse decision of the commissioner brought pursuant to 42 U.S.C. § 405(g). Plaintiff David T. Bennett challenges the commissioner's determination that he is not disabled and therefore ineligible for disability insurance benefits under sections 216(I) and 223 of the Social Security Act, codified at 42 U.S.C. §§ 416(I) and 423(d). Plaintiff claims that the administrative law judge erred by failing to adopt the opinion of plaintiff's treating doctor, Dr. Taylor, who concluded that plaintiff's back condition was equal in severity to a listed impairment and that plaintiff was incapable of sustaining even sedentary work on a full time basis.

As explained below, the ALJ determined that Dr. Taylor's opinion was contrary to the doctor's own contemporaneous treatment notes as well as other evidence in the record indicating that plaintiff's condition was neither equivalent in severity to a listed impairment

nor so disabling as to prevent plaintiff from performing all work. The ALJ properly applied the commissioner's "treating physician" rule and cited logical reasons supported by substantial evidence in the record for his determination that Dr. Taylor's opinion was entitled to little weight. Therefore, this court should reject plaintiff's argument and affirm the commissioner's decision.

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

FACTS

Plaintiff was forty-six years old on the date of the ALJ's decision. He graduated high school and completed two years of college. Plaintiff's work history included jobs as a cashier in a convenience store, an assistant manager, and a laborer.

In the early 1990s, plaintiff underwent a series of surgeries to correct herniated discs in his back. As a result, plaintiff's spine is now fused by bone grafts, screws and other hardware at the L4-5 and L5-S1 levels. Also implanted in his spine is a now-inactive bone growth stimulator.

Plaintiff recovered well from his surgeries and was able to return to work, although not to his former strenuous job as a steel foundry worker. His orthopedic surgeon, Dr. John Stark, indicated that plaintiff should be limited to light-medium work with a 20-pound lifting restriction. AR 144. From approximately October 1995 to December 2002, plaintiff worked as an assistant manager at a convenience store. Dr. Stark saw plaintiff once a year

from 1997-1999. AR 140-42. At each visit, Dr. Stark noted that plaintiff had no significant problems and was doing well; physical examination was unremarkable.

In December 2002, plaintiff quit his job and moved from Minnesota to northern Wisconsin to be with his fiancée. On January 21, 2003, plaintiff filed an application for disability insurance benefits, alleging that he was unable to work because of back injuries and depression.[1] He reported that he had stopped working on December 26, 2002 due to relocating and back pain.

At the request of the state agency, John Berry, M.D., performed a consultative examination of plaintiff in May 2003. AR 184-87. Plaintiff complained of back pain with numbness down the backs of his thighs, "giving way" of both legs, leg twitching and knee pain. AR 184. He reported that he had not obtained follow-up care for his back pain for approximately three years and that he used no medicines stronger than over-the-counter pain relievers. Dr. Berry reported that plaintiff displayed dramatic pain behavior during the examination, as he presented in a somewhat hunched over fashion, displayed dramatic loss of balance during some of the gait activities, and walked with a dramatic antalgic limp favoring his left leg. At one point, plaintiff knees appeared to give out on him and he "squatted to the floor quickly with a gasp of pain." AR 185. Dr. Berry examined plaintiff's knees and found that plaintiff had full range of motion, no significant crepitus, stability to

[1] Plaintiff does not challenge any of the ALJ's findings with respect to his mental impairment. Accordingly, I do not discuss that evidence in this report.

stress testing and no warmth, joint effusion, or bursal swelling. Dr. Berry also found reduced lumbar range of motion, positive straight leg raise test, symmetric reflexes, intact sensation except for subjectively reduced sensation over plaintiff's left big toe, and normal strength in plaintiff's extremities, except for mild hesitancy in his left hip and knee groups. Dr. Berry diagnosed chronic low back and left leg pain amplified by moderate symptom magnification. He ordered x-rays, which revealed extensive surgical changes from L4 to the upper sacrum.

At the request of the state agency, John McDermott, M.D., and Michael Baumblatt, M.D., reviewed the record evidence in May and September, 2003, respectively, and concluded that plaintiff could perform a full range of light work, that is, work requiring lifting and carrying ten pounds frequently and twenty pounds occasionally, and standing and or walking for about six hours in an eight hour workday. 20 C.F.R. § 404.1567(b).

In October 2003, plaintiff began seeing Stewart Taylor, Jr., M.D., an orthopedic surgeon. AR 223. Plaintiff complained of low back pain with radiation into his thigh and occasional numbness in his feet. Dr. Taylor ordered x-rays, which showed plaintiff's prior surgery but no significant additional degeneration. Dr. Taylor expressed concern over the "non-physiologic" nature of plaintiff's examination, noting that plaintiff displayed significant pain behavior and dropped to the floor at one point, stating that his legs suddenly gave out. Dr. Taylor recommended that plaintiff use a non-steroidal anti-inflammatory medication and limit his activities to what he could tolerate.

At a follow-up exam the next month, plaintiff reported that his symptoms were virtually unchanged. He said he slept only about 2½ to 3 hours per night, and spent the rest of his day on the computer, walking around, and helping with light household chores. AR 225. Dr. Taylor ordered a nerve conduction study, the results of which were consistent with a radiculopathy[2] involving the L5 and S1 roots on the left side. AR 226-27. Dr. Taylor noted that an MRI would help determine whether "this constitutes an operable lesion," opining that "in all probability it does not." AR 226. However, because of the hardware in plaintiff's back, he was not a candidate for an MRI or a myelogram. AR 229.

Plaintiff saw Dr. Taylor three times in 2004. In February 2004, plaintiff reported that he was worse and was not sleeping well. AR 228A. He stated that he had a hard time getting out of bed at times, and he was unable to engage in household activities such as shoveling snow because of significant discomfort. Dr. Taylor observed that plaintiff displayed considerable pain behavior, walking with bent knees and forward bending at his hips. On examination, plaintiff had essentially full range of motion of his hips, knees, feet, and ankles, straight leg raising without apparent difficulty to about seventy-five degrees, and full and symmetric reflexes. Dr. Taylor noted that it was difficult to examine plaintiff because of significant evidence of symptom magnification; he recommended physical therapy.

At a follow-up visit the next month, Dr. Taylor again noted that plaintiff displayed a "semi-theatrical accentuation that does not appear to be physiologic in nature." Although

[2] Disorder of the spinal nerve roots. *Stedman's Medical Dictionary* (27th ed.), at 1503.

plaintiff continued to complain of pain, Dr. Taylor refused to provide medications other than a sleep medication because of plaintiff's history of drug addiction. AR 229.

At a follow-up visit in May 2004, plaintiff stated that he continued to experience back pain radiating to his big toe. AR 230. Dr. Taylor uncovered nothing new, but noted that the examination was "confused because of some inconsistencies which suggest an embellishment of symptoms." Plaintiff stated that he was having financial problems and had been unable to obtain the sleep aid that Dr. Taylor prescribed; he further reported that he was not eligible for food stamps, had been unable to obtain Social Security disability benefits and had not been able to obtain a settlement for his work-related injury. Dr. Taylor stated that he "would do what I could to help with the paperwork to facilitate" these applications, but he did not recommend any follow-up treatment.

Over one year later, in July 2005, Dr. Taylor completed a questionnaire for plaintiff's attorney. AR 231-32. Dr. Taylor listed plaintiff's diagnoses as: failed back surgery with chronic pain; L5-S1 radiculopathy; substance abuse; sleep disturbance; and symptom magnification. In response to a question asking whether plaintiff would be capable of performing a light duty job on a full time basis, Dr. Taylor responded: "My belief is that as described to me and by Mr. Bennett his physical capacities at this time are far below that necessary to meet [that] standard." AR 231. In response to whether plaintiff's condition met or was medically equal to the criteria of Listings 1.04, Disorders of the Spine, Dr. Taylor

wrote that plaintiff did not meet every criteria of the listing. However, Dr. Taylor opined that plaintiff's condition was medically equal to the listing, explaining:

> I think he meets the criteria of 1.04A and B on clinical and EMG grounds. This is notwithstanding the fact that EMG is not listed specifically as a criteria. The atrophy was listed as one of the criteria as was histology and imaging studies. Atrophy was not observed by me. Histology was not available for interpretation. Imaging studies are difficult to interpret because of the metal which has been applied to achieve union in the fused segments. Notwithstanding these complicating factors I think that the criteria for A and B are met.

AR 231-32.

At his administrative hearing, plaintiff testified that he suffered excruciating, constant back pain. AR 277-78. Plaintiff rated his pain at the time of the hearing as 9.5 on a ten-point scale; he rated his typical pain as 5. AR 279. He stated that he took over-the-counter medications about every four hours which reduced but did not eliminate his pain. Plaintiff said that he could not afford medical care or prescription medications. AR 277-78. He estimated that he could stand fifteen to twenty minutes, sit ten to twenty minutes, and walk one block. AR 281. Plaintiff testified that he only slept about two hours and took naps during the day. AR 283.

Daniel Moriarty, a vocational expert , appeared and testified at the hearing. The ALJ asked Moriarty to consider a hypothetical individual who was limited to light work that involved only occasional stooping and only simple tasks. AR 285. Moriarty testified that an individual of plaintiff's age, education, and work history with those limitations could

perform jobs such as office helper (2187 jobs in the State of Wisconsin and 84,000 jobs in the nation), assembler (1500 jobs in the State of Wisconsin and 525,000 jobs in the nation), and food assembler (1356 jobs in the State of Wisconsin and 334,000 jobs in the nation). AR 286.

On October 7, 2005, the ALJ issued a decision finding that plaintiff was not disabled. Applying the commissioner's five-step process for evaluation disability claims, *see* 20 C.F.R. § 404.1520, the ALJ first determined that plaintiff had not engaged in substantial gainful activity after his alleged onset date. At step two, the ALJ found that plaintiff had severe impairments: degenerative disc disease at L4-5 and L5-S1 and depression. At step three, the ALJ found that the impairments, either singly or combined, were not severe enough to meet or medically equal one of the impairments presumed to be disabling at Appendix 1, Subpart P, Regulations No. 4 (the Listings). With respect to plaintiff's back impairment, the ALJ compared the evidence to Listing 1.04 (Disorders of the Spine) and determined that plaintiff did not meet that listing because he did not have nerve root compression characterized by pain, limitation of motion of the spine, motor loss, or atrophy with associated muscle weakness, accompanied by sensory or reflex loss.

In reaching this conclusion, the ALJ rejected Dr. Taylor's opinion that plaintiff's back condition was medically equal to the listing, explaining:

> Social Security Regulations provide that the opinion of a treating physician is entitled to significant evidentiary weight if it is well supported by objective clinical findings and not contrary to the opinions of the other treating and examining

> physicians in the record. However, Dr. Taylor has submitted no treatment records or progress notes to support his conclusion. In fact all the medical records from Dr. Taylor indicate that the claimant has exaggerated his pain complaints. And, while Dr. Taylor states that the claimant's impairment is medically equal to a listed impairment he has not found it necessary to place any limitations on the claimant regarding working, walking, standing, sitting or lifting. Objective findings on x-ray studies have found no evidence of new or worsening degenerative changes. In addition, I note that the opinion of Dr. Taylor express in Exhibit 13F is entirely contrary to that of the other examining physicians in the record and contrary to his own treatment records and progress notes.

AR 20.

The ALJ then assessed plaintiff's residual functional capacity and found that he retained the ability to perform light work requiring only occasional stooping and only simple, repetitive tasks. Relying on the testimony of the vocational expert, the ALJ found at step four that plaintiff was unable to perform his past work. At step five, again relying on the expert's testimony, the ALJ found that plaintiff nonetheless could make a vocational adjustment to other types of work, including office helper, assembler and food handler, and that such jobs existed in significant numbers in the regional economy. Thus, 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).

II. Dr. Taylor's Opinion

Plaintiff's sole claim in this appeal is that the ALJ did not properly evaluate Dr. Taylor's opinion. Specifically, plaintiff contends the ALJ failed to cite logical reasons for rejecting both Dr. Taylor's opinion that plaintiff's condition was medically equal in severity to a listed impairment and his opinion that plaintiff was unable to perform even a sedentary job on a full-time basis.

Plaintiff is incorrect. An administrative law judge must give controlling weight to the medical opinion of a treating physician if it is "well-supported by medically acceptable clinical and laboratory diagnostic techniques" and "not inconsistent with the other substantial evidence." *Hofslien v. Barnhart*, 439 F.3d 375, 376 (7th Cir. 2006); 20 C.F.R. § 404.1527(d)(2). Here, the ALJ explained that Dr. Taylor's opinion did not meet this standard, pointing out that Dr. Taylor's opinion that plaintiff's condition was equal in severity to a listed impairment was contradicted by his treatment notes, which documented no significant abnormalities and remarked repeatedly that plaintiff appeared to be exaggerating his pain. The ALJ noted that x-rays showed that plaintiff's fusion remained solid and he had no significant additional degenerative changes. In addition, Dr. Taylor's finding of medical equivalency was contradicted by Dr. Berry, the consultative examiner, who also found no significant abnormalities. Each of the ALJ's findings is supported by the evidence; added together, they justify his determination to afford little weight to Dr. Taylor's opinion.

Seizing on an isolated paragraph in the ALJ's decision, plaintiff argues that the ALJ rejected Dr. Taylor's opinion on medical equivalence because plaintiff did not meet the criteria of Listing 1.04. Plaintiff is correct that such reasoning would be illogical: the question of medical equivalence becomes relevant precisely when a claimant does not specifically meet the criteria of a listing. *See* 20 C.F.R. § 404.1526; Soc. Sec. Ruling 86-8. However, when one reads the ALJ's opinion as a whole, it is clear that the ALJ did not employ such reasoning. After the paragraph cited by plaintiff, the ALJ explained why Dr. Taylor's opinion of medical equivalence was not well-supported, pointing out that Dr. Taylor had not placed any work-related restrictions on plaintiff and that Dr. Taylor's opinion was contradicted by his own treatment notes as well as that of other examining physicians, presumably Dr. Berry and Dr. Stark. The ALJ did not reject Dr. Taylor's opinion on medical equivalence because plaintiff did not meet the listing. He rejected it because it was poorly explained and inconsistent with the rest of the record, which failed to document medical findings "at least equal in severity and duration to the listed findings." 20 C.F.R. § 404.1526(a). Moreover (and contrary to plaintiff's assertion), the ALJ's explanation of his reasons for rejecting Dr. Taylor's opinion makes plain why the ALJ determined that plaintiff's condition was not medically equal to a listed impairment.

Plaintiff argues that even if the ALJ was justified in rejecting Dr. Taylor's opinion on medical equivalence, he had no legitimate reason to reject the doctor's opinion that plaintiff would be unable to sustain even sedentary work on a full time basis. Plaintiff asserts that

the ALJ rejected this aspect of Dr. Taylor's opinion on the ground that Dr. Taylor had not placed any limitations on plaintiff regarding working, walking, standing, sitting or lifting. Plaintiff argues that this reasoning is illogical, pointing out that Dr. Taylor was not asked to assess plaintiff's work-related limitations, but was simply asked whether he thought plaintiff could sustain sedentary work on a full time basis.

Again, plaintiff is focusing on a few trees and ignoring the forest. Giving the ALJ's decision a common-sense reading, as this court must, it is clear that the ALJ was referring not to Dr. Taylor's failure to assign work-related restrictions to plaintiff in response to the questionnaire he answered at the request of plaintiff's attorney, but to his failure to record any such work limitations in any of his treatment notes. As the ALJ pointed out, although plaintiff purported to be in excruciating pain, Dr. Taylor recommended only physical therapy and gave no indication that plaintiff should limit his sitting, standing, walking or lifting. The ALJ also noted that not only had Dr. Taylor failed to explain the basis for his opinion that plaintiff could not sustain sedentary work, but that his conclusion was not supported by the other evidence in the record. Finally, the ALJ noted that both Dr. Taylor and Dr. Berry had observed significant symptom magnification by plaintiff. These were adequate reasons for the ALJ to reject Dr. Taylor's opinion regarding plaintiff's ability to sustain full time work.

Plaintiff argues that the only other evidence in the record concerning whether his condition equaled a listing or was so limiting as to preclude him from performing substantial

gainful activity was the opinions of the agency consulting physicians. Plaintiff contends that the ALJ was obliged to accept Dr. Taylor's opinion over theirs because the agency physicians did not consider Dr. Taylor's treatment notes when they issued their opinions in 2003. However, plaintiff fails to cite anything in Dr. Taylor's treatment notes that would suggest plaintiff's condition worsened significantly after 2003. Although Dr. Taylor did order testing that revealed a radiculopathy, his physical examinations of plaintiff, like that performed a year earlier by the consultative examiner, Dr. Berry, revealed so few abnormalities that Dr. Taylor concluded that no further treatment was necessary. As the ALJ observed, Dr. Taylor's treatment notes offered no suggestion that plaintiff was suffering from a disabling condition; to the contrary, they suggested that for the most part, plaintiff was faking his symptoms. In light of this, the ALJ was well within his discretion as the fact finder to reject Dr. Taylor's opinion.

RECOMMENDATION

Pursuant to 28 U.S.C. § 636(b)(1)(B) and for the reasons stated above, I recommend that the decision of the Commissioner denying plaintiff David T. Bennett's application for disability insurance benefits be affirmed.

Entered this 4th day of July, 2006.

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

UNITED STATES DISTRICT COURT
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July 5, 2006

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Re: Bennett v. Barnhart
Case No. 06-C-0027-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 25, 2006, by filing a memorandum with the court with a copy to opposing counsel.

If no memorandum is received by July 25, 2006, the court will proceed to consider the magistrate judge's Report and Recommendation.

Sincerely,
/s/ S. Vogel for
Connie A. Korth
Secretary to Magistrate Judge Crocker

Enclosures
cc: Honorable Barbara B. Crabb, District Judge