IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF WISCONSIN

MATTHEW T. STARY,

Plaintiff,

v.

MEMORANDUM AND ORDER
06-C-082-S

JO ANNE B. BARNHART,
Commissioner of Social Security,

Defendant.

Plaintiff Matthew T. Stary commenced this action pursuant to 42 U.S.C. § 405(g) for review of the defendant Commissioner's final decision denying him Disability Insurance Benefits (DIB) and Supplemental Security Income (SSI). He asks the Court to reverse the decision or to remand for further proceedings.

Plaintiff applied for DIB and SSI on January 24, 2002 alleging disability beginning January 31, 2001 due to depression and anxiety. His application was denied initially and upon reconsideration. A hearing was held on September 16, 2004 before Administrative Law Judge (ALJ) Robert Thomas. In a March 22, 2005 written decision the ALJ found plaintiff not disabled. The ALJ's decision became the final decision of the Commissioner when the Appeals Council denied plaintiff's request for review on January 9, 2006.

FACTS

Plaintiff was born on May 3, 1962. He has a college education and past relevant work experience as a photographer, retail manager, fund raising director and news writer.

In March 2000 plaintiff was seen by Judith Doersch, MSW, for depression. Bernard Green, Ph.D., saw plaintiff on March 30, 2000. Plaintiff complained of anxiety, depression and forgetfulness but denied any suicidal or homicidal ideation. He was taking Wellbutrin and seeing a therapist on a semi-regular basis. Dr. Green diagnosed plaintiff with a dsythymic disorder. Plaintiff saw Ms. Doersch on April 3 and April 7, 2000 but then did not return to see her until September 13, 2000.

Plaintiff returned to see Dr. Green on January 26, 2001 and reported that he was depressed and lonely. Plaintiff reported he was taking Paxil and Wellbutrin as well as Lorazepam and Darvocet. He indicated he was experiencing some suicidal thoughts but was able to control them.

In January 2002 plaintiff was seen by Dr. Lee Cody, an internist. Plaintiff reported that he had good control of symptoms of depression with anxiety with Wellbutrin and Paxil but had recently been changed from Paxil to Prozac and was experiencing increased depression and anxiety. He denied any suicidal ideation. Dr. Cody changed plaintiff from Prozac to Celexa but in February changed the Celexa to Paxil.

On March 13, 2002 plaintiff was seen for a psychiatric evaluation by Dr. Alpa Shah, M.D. She noted he was using Xanax and Darvocet inappropriately for mood-altering purposes and was continuing to use alcohol. Dr. Shah diagnosed plaintiff with an anxiety disorder and a depressive disorder with a Global Assessment of Functioning of 45-50 in the severe range. Dr. Shah changed plaintiff's prescription of Xanax to Klonopin, increased his Paxil and reduced his Wellbrutin. She advised plaintiff to discontinue taking Darvocet and using alcohol. Dr. Shah referred plaintiff for psychotherapy.

When plaintiff saw Dr. Shah on April 5, 2002 he admitted that he was still taking Xanax and drinking. He refused a chemical dependency evaluation. Plaintiff called Dr. Shah on April 11, 2002 to report that he had discontinued Xanax and wanted a prescription for Klonopin. On May 2, 2002 plaintiff reported to Dr. Shah that he was feeling more depressed but continued to use Darvocet and alcohol. He also reported that he has some suicidal ideation but was able to distract himself.

On May 10, 2002 plaintiff was seen by Anthony Lewis, MSW. He was seen by Dr. Shah on the same day. They recommended a chemical dependency evaluation for plaintiff but he would not consider it. He did not return to see either Dr. Shah or Mr. Lewis but began seeing Dr. Michael Oberg, a psychiatrist, on August 30, 2002. Dr. Oberg diagnosed plaintiff with a mood disorder, a history of

substance use disorder and Cluster B personality traits. He continued plaintiff on Paxil, Klonopin and Wellbutrin.

On September 5, 2002 plaintiff was seen by Claudia Bodway, Ph.D., for a consultative psychological evaluation at the request of the Social Security Administration. Plaintiff was diagnosed with a history of severe depression, recurrent and a history of anxiety and panic attacks, recurrent. He was given a Global Assessment of Functioning of 45 in the severe range.

On September 20, 2002 he was seen for a second consultative evaluation by Roger R. Ricketts, Psy. D. Plaintiff was diagnosed with a history of polysubstance abuse, with an anxiety disorder, a depressive disorder and cluster B personality traits with a Global Assessment of Functioning of 55 in the moderate range.

On October 7, 2002 plaintiff was seen by Dr. Oberg and reported some variable symptoms of depression and anxiety. Dr. Oberg indicated his Global Assessment of Functioning was 55 in the moderate range. Plaintiff returned to Dr. Oberg on December 16, 2002 and his Global Assessment of Functioning was the same. Plaintiff was advised to increase Wellbutrin and return to psychotherapy.

On January 21, 2003 plaintiff began seeing Patricia Faber, MSW. He complained of some irritability and aggression. He was diagnosed with a mood disorder and a personality disorder.

On January 27, 2003 plaintiff saw Dr. Oberg and reported increased irritability on increased Wellbutrin. Dr. Oberg rated plaintiff's Global Assessment of Functioning at 50 in the severe range, decreased Wellbutrin and added Effexor. Plaintiff cancelled his March 5, 2003 appointment with Dr. Oberg but indicated that he was doing well.

Plaintiff saw Dr. Oberg On April 22, 2003. Dr. Oberg rated his Global Assessment of Functioning at 50, in the severe range. Subsequent telephone calls from plaintiff to Dr. Oberg indicated that plaintiff was more irritable and using medications inappropriately. Plaintiff saw Ms. Faber on June 2, 2003 and reported he was doing fairly well in terms of mood. On June 25, 2003 plaintiff saw Dr. Oberg and was depressed. The doctor rated plaintiff's Global Assessment of Functioning between 50-60 in the severe to moderate range.

When Dr. Oberg saw plaintiff on August 12, 2003 he was inattentive with reduced mood and affect but his Global Assessment of Functioning was 55 to 60 in the moderate range. Shortly thereafter plaintiff's father died. When Dr. Oberg saw plaintiff on September 9, 2003 his Global Assessment of Functioning was 50, in the severe range. He was advised to make a therapy appointment. Plaintiff saw Ms. Faber on September 19, 2003 and discussed bereavement issues.

On October 9, 2003 plaintiff saw Dr. Oberg who indicated his Global Assessment of Functioning was 45 in the severe range. Dr. Oberg advised plaintiff to resume therapy. Plaintiff did not return to see Dr. Oberg until April 27, 2004. His Global Assessment of Functioning remained at 45.

On October 11, 2002 a state agency psychologist, Anthony J. Matkom, completed a Psychiatric Review Technique form for plaintiff noting that plaintiff's mental impairments moderately affected his activities of daily living, social functioning and maintaining concentration, persistence or pace. He found no episodes of decompensation of extended duration. He found that there was no evidence of the C criteria of the listings. Dr. Jack Spear affirmed this finding on June 2, 2003.

Both doctors found that plaintiff was moderately limited in his ability to understand, remember and carry out detailed instructions; to maintain attention and concentration for extended periods; to perform activities within a schedule, maintain regular attendance and be punctual within customary tolerances; to work in coordination with or proximity to others without being distracted by them; to interact appropriately with the general public, the ability to accept instructions and respond appropriately to criticism from supervisors; to get along with co-workers or peers without distracting them or exhibiting behavior extremes; to respond appropriately to changes in the work setting; to travel in

unfamiliar places and use public transportation and to set realistic goals or make plans independently of others.

At the September 16, 2004 hearing before the ALJ plaintiff appeared with counsel and testified that he had his own photography business and that stress was not a significant factor in his work. He testified that although he sometimes postponed senior high portraits he never canceled wedding photography appointments. He further testified that he was able to keep his home clean and enjoyed yard work. Plaintiff testified that he slept all day three days a month.

Michael Lace, a medical expert, testified that plaintiff's medical record documented a mood order which met the Listed Impairment 12.04 with symptoms of anxiety subsumed under this diagnosis. He testified that plaintiff had moderate restriction of activities of daily living and moderate difficulties in maintaining social functioning and maintaining concentration, persistence or pace but no episodes of decompensation of extended duration. Dr. Lace concluded that the record documented a residual disease process that had resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the claimant to decompensate which met #2 of the C criteria of the listed impairment, 12.04.

William Dingess, a vocational expert, testified at the hearing after listening to the testimony and reviewing the record. The ALJ

asked him what jobs an individual of plaintiff's age, education and past work experience with plaintiff's residual functional capacity could perform. The ALJ found plaintiff had the residual functional capacity to perform work requiring lifting 50 pounds occasionally and 25 pounds frequently with routine repetitive work tasks in a reduced stress environment with few changes in job tasks, no high productions quota or assembly-line pace and brief and superficial contact with others. The vocational expert testified that there were general clerk jobs (1500 jobs), stock and inventory clerk jobs (1600 jobs) assembler (21,600 jobs), production inspector (3420 jobs) and hand packager (10,800 jobs).

By letter dated November 15, 2004 Dr. Oberg reported that plaintiff does not appear to have any problems with the activities of daily living but he is impaired in his ability to work near and with other people and in his ability to sustain pace and effort. He noted that plaintiff had impaired ability to complete tasks in a timely manner and difficulty in following instructions, maintaining regular attendance and being punctual. Dr. Oberg also indicated that plaintiff had impaired ability to cope with normal work stress and changes in work routine. Dr. Oberg stated as follows: "He has a history of work dysfunction with decompensation in work settings that have caused him to withdraw in the past, work settings have exacerbated his symptoms and there has been deterioration of adaptive behaviors." Dr. Oberg concluded that

plaintiff's predicted term of impairment is indefinite and that he is not a malingerer

In his written decision the ALJ found that plaintiff had severe physical impairments of a history of left shoulder arthroscopy in January 2001 for a labrum tear, with subsequent left shoulder strain in April 2002, with imaging evidence of mild degenerative changes in AC joint, recurrent prostatitis and right shoulder impingement. He also found that plaintiff had a severe mental impairment of mood disorder with associated anxiety disorder and substance addiction disorder but that his impairments singly or in combination did not meet a listed impairment.

The ALJ discounted Dr. Lace's opinion that plaintiff had a 12.04 Listed Impairment stating that the medical record did not support his opinion. The ALJ wrote as follows, "Medical reports indicate fluctuations in the claimants' Global Assessment of Functioning particularly related to bereavement, but otherwise indicate functioning essentially in the moderate range, despite non-compliance with mental health follow-up, inappropriate use of psychotropic and narcotic medications and continued alcohol abuse." The ALJ also noted that although Dr. Oberg felt that plaintiff was impaired in his ability to work he did not quantify these impairments. The ALj further states that the record did not contain specific information concerning plaintiff's past employment problems.

The ALJ found that plaintiff retained the residual functional capacity to perform work requiring lifting 50 pounds occasionally and 25 pounds frequently with routine repetitive work tasks in a reduced stress environment with few changes in job tasks, no high productions quota or assembly-line pace and brief and superficial contact with others. The ALJ found that plaintiff's testimony concerning further reduction in his residual functional capacity was not credible based on the record as a whole. Based on the testimony of the vocational expert that there was a significant number of jobs in the economy that plaintiff could perform the ALJ found plaintiff not disabled.

The ALJ made the following findings:

> 1. The claimant met the disability insured status requirements of the Act on January 31, 2001, his alleged onset date of disability, and continues to meet them through the date of this decision.
>
> 2. The claimant has not engaged in substantial gainful activity at any time since January 31, 2001.
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> 3. The medical record establishes that the claimant is severely impaired by a history of left shoulder arthroscopy for a labral tear, with subsequent left shoulder strain, with imaging evidence of mild degenerative changes in the AC joint, recurrent prostatitis, acute right shoulder impairment, a mood disorder, NOS, with associated anxiety disorder, NOS, and a substance abuse/addiction disorder, but that he does not have an impairment or combination of impairments that meets or equals the relevant criteria of any impairment listed at 20 C.F.R. Part 404, Subpart P, Appendix 1.

4. The claimant's subjective complaints and functional limitations are inconsistent with the record as a whole.

5. The claimant retains the residual functional capacity for work requiring lifting 50 pounds occasionally and 25 pounds frequently, with routine repetitive work tasks, in a reduced stress environment, with few changes in job tasks, no high productions quotas or assembly-line pace, and brief and superficial contact with others.

6. The claimant's impairment precludes him from returning to his past relevant work.

7. The claimant is a younger individual, with more than a high school education, and a history of semi-skilled to skilled work.

8. Considering the claimant's residual functional capacity, age, education, and past work experience, there are other jobs the claimant is capable of performing that exist in significant numbers in the national economy, including general office clerk (1500 jobs), stock and inventory clerk (1600 jobs), assembler (21,600 jobs), production inspector (3420 jobs) and hand packager (10,800 jobs).

9. The claimant has not been under a disability as defined in the Social Security Act at any time since January 31, 2001.

OPINION

This Court must determine whether the decision of the Commissioner that plaintiff was not disabled is based on substantial evidence pursuant to 42 U.S.C. § 405(g). See Arbogast v. Bowen, 860 F.2d 1400, 1402-1403 (7th Cir. 1988). Substantial evidence is defined as "such relevant evidence as a reasonable mind

might accept as adequate to support a conclusion." Richardson v. Perales, 402 U.S. 389, 401 (1971).

Disability determinations are made pursuant to a five-step sequential evaluation procedure. 20 CFR § 404.1520(a)-(f). First, the claimant must not be performing substantial gainful activity. Second, the claimant must have a severe, medically determinable impairment. Third, a claimant will be found disabled if his or her impairment is equal in severity to a listed impairment in 20 C.F.R. Subpart P, Appendix 1. Fourth, if the claimant does not meet the third test, he/she must not be able to perform his/her past work. Fifth, if the claimant cannot perform his/her past work, he or she must not be able to perform any existing jobs available in the national economy given his or her educational background, vocational history and residual functional capacity.

The ALJ found that plaintiff had severe physical impairments of a history of left shoulder arthroscopy in January 2001 for a labrum tear, with subsequent left shoulder strain in April 2002, with imaging evidence of mild degenerative changes in AC joint, recurrent prostatitis and right shoulder impingement. He also found that plaintiff had a severe mental impairment of mood disorder with associated anxiety disorder and substance addiction disorder but that his impairments singly or in combination did not meet a listed impairment.

The ALJ further found that plaintiff retained the residual functional capacity to perform work requiring lifting 50 pounds occasionally and 25 pounds frequently with routine repetitive work tasks in a reduced stress environment with few changes in job tasks, no high productions quota or assembly-line pace and brief and superficial contact with others. Based on the testimony of the vocational expert the ALJ found that plaintiff was not disabled because there were jobs available that he could perform in significant numbers in the national economy.

Plaintiff contends that there is not substantial evidence in the record to support the ALJ's finding that his mental impairment did not meet or equal a listed impairment. To meet the listed impairment 12.04 plaintiff must show he met the criteria of 12.04 C which provides:

> C. Medically documented history of a chronic affective disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities with symptoms or signs currently attenuated by medication or psychosocial support and one of the following:
> 1. Repeated episodes of decompensation, each of extended duration; or
> 2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate or
> 3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

Plaintiff claims that he meets the requirements of 12.04C(2). Since 2000 plaintiff has been treated for depression and anxiety. Both state agency psychologists who completed Psychiatric Review Technique Forms concluded that plaintiff's mental impairments moderately affected his activities of daily living, social functioning and maintaining concentration, persistence or pace but found no episodes of decompensation of extended duration. They concluded that plaintiff did not meet the C criteria of 12.04.

On the other hand the medical expert, Dr. Michael Lace, who testified at the hearing, found plaintiff's mental impairment met the listed impairment 12.04C (2). Although Dr. Lace concurred with the state agency psychologists that plaintiff's impairment only moderately affected his activities of daily living, maintaining social functioning and concentration, he concluded that the medical record supported the finding that plaintiff met the C criteria of the 12.04 listed impairment. He found that plaintiff had a residual disease process that has resulted in such marginal adjustment that even a minimal increase in the mental demands or change in the environment would be predicted to cause the individual to decompensate. Plaintiff's treating physician Dr. Oberg also reported that plaintiff had an impairment which affected his ability to work even though it did not restrict his activities of daily living. He concluded that plaintiff had impaired ability

to cope with normal work stress and changes in work routine with a history of decompensation in work history.

The medical record supports the ALJ's conclusion that plaintiff was not impaired in his activities of daily living. The evidence, however, is inconsistent concerning whether plaintiff met the C criteria of Listing 12.04. The medical expert and plaintiff's treating physician found that he did.

` The ALJ found that the opinion of Dr. Lace was not supported by the record as whole because plaintiff's functioning was essentially in the moderate range. This statement is incorrect because the record indicates otherwise. Dr. Shah rated plaintiff's Global Assessment of Functioning in March 2002 at 45-50 which was in the severe range. In September 2002 Dr. Bodway gave plaintiff the same rating. Plaintiff's Global Assessment of Functioning then improved in late 2002 to 55 which was in the moderate range. In 2003 plaintiff was rated at 50 in the severe range twice by Dr. Oberg. In the summer of 2003 plaintiff was rated 50-60 in the severe to moderate range. After his father's death plaintiff's Global Assessment of Functioning dropped to 50 and 45 in the severe range.

Plaintiff's functioning was rated in the severe range in 2002 by Dr. Shaw and Dr. Bodway and in 2003 by Dr. Oberg. This does not support the ALJ's conclusion that plaintiff's functioning was essentially in the moderate range. The reason that the ALJ gave for discounting Dr. Lace's opinion was insufficient.

The opinion of Dr. Oberg, plaintiff's treating physician, is to be given controlling weight if it is well-supported by medically accepted clinical and laboratory diagnostic techniques and not inconsistent with the other substantial evidence in the record. See 20 C.F.R. §§ 404.1527(d)(2), 416.927(d)(2); SSR 96-2p. The ALJ did not discuss the weight to be accorded Dr. Oberg's opinion but discounted Dr. Oberg's conclusion concerning decompensation in work settings finding that there was no evidence in the record of plaintiff's past employment problems. He also stated that Dr. Oberg failed to quantify plaintiff's impairments. The ALJ's consideration of Dr. Oberg's opinion does not comply with the regulations. Specifically, Dr. Oberg's opinion is not inconsistent with other substantial evidence in the record.

Failure to provide good reasons for discrediting a doctor's opinion is alone grounds for remand. Clifford v. Apfel, 227 F.3d 863, 870 (7th Cir. 2000). The ALJ must "minimally articulate his reasons for crediting or rejecting evidence of disability." Scivally v. Sullivan, 966 F.2d 1070, 1076 (7th Cir. 1992). It is the responsibility of the ALJ and not the Commissioner's attorney to articulate the weight to be given to the opinions of the plaintiff's treating physicians. See Dixon v. Massanari, 270 F.3d 1171, 1176 (7th Cir. 2001). The ALJ has failed to provide good reasons for not giving Dr. Oberg's opinion controlling weight.

The ALJ concluded that there was no evidence that plaintiff met the C criteria of the listing. He does not, however, cite to evidence in the record that plaintiff's impairment would not cause him to decompensate in work settings where there was a minimal increase in mental demands or change in the environment. The ALJ's reasons for his conclusion are not adequately articulated or supported by substantial evidence. Accordingly, the Court will remand this case to the Commissioner to further consider the weight to be given the opinions of the medical expert and plaintiff's treating physician.

The Court cannot conclude as plaintiff suggests that he should be awarded benefits upon the current record. Additional fact finding may be required as to determine whether plaintiff's impairment would cause future decompensation in work settings. The Court finds no evidence in the record that would suggest any bias of the ALJ which would require assignment to a different ALJ upon remand.

ORDER

IT IS ORDERED that the above entitled matter is REMANDED to the Commissioner for further proceedings consistent with this opinion.

Entered this day of July 2006.

BY THE COURT:

S/

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JOHN C. SHABAZ
District Judge