IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF WISCONSIN

SUSAN MALUEG,

Plaintiff,

v. MEMORANDUM AND ORDER

MICHAEL J. ASTRUE, 06-C-676-S
COMMISSIONER OF SOCIAL SECURITY,

Defendant.

Plaintiff Susan Maleug brings this action pursuant to 42 U.S.C. § 405(g) for review of the defendant Commissioner's final decision denying her Disability Insurance Benefits (DIB) and Supplemental Security Income (SSI). She asks the Court to reverse the decision or in the alternative to remand for further proceedings.

Plaintiff applied for DIB and SSI on December 3, 2001 alleging disability due to costochondritis, psoriasis, anxiety, depression, back pain and headaches. Her application was denied initially and upon reconsideration. A hearing was held on September 30, 2002 before Administrative Law Judge (ALJ) Diane Townsend-Anderson. In a written decision dated February 27, 2003 the ALJ found plaintiff was not disabled because she was capable of performing a significant number of jobs in the economy. The ALJ's decision

became the final decision of the Commissioner when the Appeals Council denied plaintiff's request for review on February 15, 2006.

FACTS

Plaintiff was born on February 10, 1968. She received her GED and worked as a bartender and waitress until March 20, 2000.

MEDICAL EVIDENCE

In November 1999 plainitff was treated by Dr. Kathleen Tonti-Horne at the Duluth Clinic-Ashland for costochondritis, anxiety and psoriasis. On January 7, 2000 plaintiff reported that her costochondritis was worse and was prescribed Vioxx.

Plaintiff began psychiatric treatment with James Lean, M.D. on November 1, 1999 for anxiety. She saw Dr. Lean several times until April 9, 2001.

On December 14, 2000 a CT scan of plaintiff's chest showed no abnormalities of the sternum or ribs. On January 18, 2001 a bone scan demonstrated some degenerative changes in plaintiff's shoulders and sternal clavicular joints.

On February 16, 2001 plaintiff saw rheumatologist Howard J. Swanson, M.D. for chest wall pain. On examination plainitff had diffuse costochondral pain and lower rib end tenderness to palpation. There was some mild pain and tenderness in some parts of her body but no exquisite fibromyalgia trigger points. Dr. Swanson indicated plaintiff had persistent costochondritis and a

complex psychiatric history. On February 22, 2001 Dr. Swanson advised plaintiff that she did not have any inflammatory arthritis.

On March 21, 2001 plaintiff saw Dr. Swanson for chest wall pain. He found that plaintiff had costochondral discomfort and rib end tenderness in her lower ribs, left greater than right. He prescribed Vioxx for her and recommended psychotherapy.

On May 8, 2001 plaintiff began treatment for primary care with Everin Houkom, M.D. who diagnosed her with costochondritis. Dr. Houkom prescribed Fioricet for plaintiff's headaches and Amitriptyline for her chronic pain. Dr. Houkom referred plainitff to the pain clinic where she was evaluated by Dr. Michael Larson. Dr. Larson noted that plaintiff had a significant anxiety disorder that required further attention but that she had recently used street drugs to attempt to avoid her stressors. Dr. Larson concluded that plaintiff had a pain disorder associated with psychological factors.

On June 12, 2001 plainitff saw Dr. Houkom for migraine headaches. He prescribed Amerge for her. He again referred her to the pain clinic where she was seen by Dr. Thomas Simpson on June 22, 2001. Dr. Simpson ordered an MRI scan of plaintiff's thoracic spine which was normal. He prescribed a TENS unit for her. On July 17, 2001 plaintiff had a thoracic epidurogram. On August 28, 2001 plaintiff had a lumbar epidural steroid injection.

From August 7 to 14, 2001 plaintiff was voluntarily hospitalized due to suicidal ideation. She was discharged with depressive disorder NOS and instructed to follow up with Dr. Vaughn. Her GAF was 55 at that time which indicates moderate symptoms.

On August 29, 2001 plaintiff's treating medical providers at the pain clinic formulated an interdisciplinary treatment plan which included counseling, aqua therapy, receiving pain medication from Dr. Houkom and abstaining from street drug use with submission to drug testing.

On August 30, 2001 plaintiff sought treatment from Dr. Simpson for neck, upper back and head pain. Dr. Simpson noted that the origin of plaintiff's pain may be occipital neuralgia with secondary myofascial pain. He administered a left occipital nerve block and prescribed Flexeril, a muscle relaxant.

Plaintiff was hospitalized from September 21 to 24, 2001 for an intractable migraine headache associated with nausea and vomiting. Dr. Houkom noted that chronic medicine dependence was an issue for plainitff. Dr. Houkom prescribed Nadolol for plainitff as a migraine preventative and discharged her on the Fentanyl patch, Prozac, Lorazepam and Vicodin.

On January 7, 2002 plaintiff saw neurologist Francine J. Vriesendorp, M.D. for headaches and neck pain. She noted that plaintiff's migraines had decreased to one per week on the Nadolol. A neurological examination of plaintiff was completely normal. Dr.

Vriesendorp advised plaintiff to increase her Nadolol dosage, seek psychiatric treatment and remain physically active. She was of the opinion that plaintiff's pain was most likely due to fibromyalgia with a superimposed psychiatric disorder.

On January 21, 2002 Dr. Houkom prescribed plainitff with one month's supply of Oxycontin. On February 1, 2002 Dr. Houkom prescribed ten fentanyl patches with no refill for plainitff. On February 15, 2002 he prescribed 30 hydrocodone for plaintiff's break through pain and on February 20, 2002 he prescribed another one month's supply of Oxycontin.

On February 21, 2002 a state agency psychologist, Anthony J. Matkom, Ph.D., completed Mental Residual Functional Capacity(RFC) Assessment form and a Psychiatrist Review Technique form for plaintiff. He noted on the Mental RFC Assessment form in his summary conclusions that plainitff was markedly limited in her ability to complete a normal work day and work week without interruptions.

When he completed the Psychiatric Review Technique form he determined that plainitff had an affective disorder under Listing 12.04 and completed Section III, Rating of Functional Limitations. He concluded that plaintiff had only moderate limitations in restrictions of activities of daily living, difficulties in maintaining social functioning and difficulties in maintaining concentration, persistence or pace and only one or two episodes of

decompensation. He found that she did not meet the C criteria of Listing 12.04.

In his narrative, Section IV of the form, Dr. Matkom concluded that plainitff could mentally perform simple repetitive work if she abstained from alcohol. On March 12, 2002 another state agency psychologist reviewed the record and concurred with this opinion.

On March 6 and 8, 2002 Dr. Houkom advised plaintiff that he could not refill her hydrocodone prescription as it was too soon. He also advised her that she should not be using fentanyl patches when she was taking Oxycontin. Dr. Houkom recommended plainitff have one doctor control her medications. At this point Dr. Houkom terminated his treatment of plaintiff.

Plaintiff then established primary care with Thomas Cunningham who renewed her prescriptions. On April 26, 2002 Dr. Cunningham noted that plaintiff's headaches were improved.

On August 1, 2002 plaintiff saw therapist Carol Lumel, LICSW for a clinical assessment. Plainitff saw Ms. Lumel for individual therapy sessions from August 8 to September 19, 2002. Ms. Lumel completed a Medical Source Statement of Ability to do Work-related Activities (Mental) for plaintiff indicating "extreme" impairments in the abilities to respond appropriately to work pressures in a ususal work setting and understand, remember and carry out detailed instructions; marked impairments in the abilities to understand, remember and carry out short, simple instructions; make judgments

on simple work-related decisions and interact appropriately with the public and moderate limitations in the abilities to interact appropriately with co-workers and supervisors.

On February 25, 2002 a state agency physician reviewed the record and opined that plaintiff could physically perform a full range of medium work. On March 12, 2002 a second state agency physician reviewed the record and reached the same decision.

HEARING TESTIMONY

At the September 9, 2002 hearing before the ALJ plaintiff appeared with counsel and testified that she was late to the hearing because she was vomiting all morning. She testified that she believed it was because of stress but that her doctor thought it was a side effect of her medication. She further testified that she could sit only for 20 to 30 minutes before she had to stand, move around and stretch. Plaintiff also testified that she could stand for about one-half hour, walk about one-half mile and lift about 15 pounds.

Plaintiff further testified that she is often late for work, often has to leave early and often calls in sick. At the hearing plainitff was taking the following medications: Lorazepam, Prozac, Nadalol, Imitrex, Ibuprofen and Vicodin and was using a TENS unit almost daily. Plaintiff's daily activities included housework, taking care of her animals and gardening. Plaintiff's other

activities included canning, crafts, painting, walking and swimming.

A medical expert, Karen Butler, Ph.D., testified after listening to the testimony and reviewing the medical record. She testified that plainitff had a diagnosis of major depression recurrent, anxiety disorder and polysubstance abuse but that she did not meet the C criteria of either listing 12.04, Affective Disorder, or 12.06, Anxiety Disorder. The expert further testified that plaintiff could perform routine and repetitive work with brief and superficial contact with the public, co-workers and supervisors. She further testified that plaintiff's work should not be rapidly paced or have high production goals and should be in an alcohol free environment. In answer to a question by plaintiff's counsel, Dr. Butler testified that the opinion of plaintiff's therapist Carol Lumel that plaintiff had extreme or marked limitations was inconsistent with the objective medical evidence.

Edward Utities, a vocational expert, was present at the hearing and had reviewed the record. The ALJ asked the expert whether an individual with the claimant's age, education, work experience and residual functional capacity could perform any jobs in the regional economy advising that plaintiff retained the residual functional capacity to lift and carry 10 pounds frequently and 20 pounds occasionally; stand/walk six hours per eight-hour day

and sit six hours per day, with the ability to change positions every 30 minutes; perform routine, repetitive work that is low stress in nature, without high production goals or rapid pace, with brief contact with others and work only in an alcohol and drug-free environment with easy access to bathroom facilities.

The vocational expert testified that such a person would be unable to perform plaintiff's past work but that she could perform a significant number of jobs existing in the national economy including wrapper/packager (5,000 jobs in the regional economy) and folder/machine operator (2,100 jobs). The expert testified that the wrapper/packager jobs included bander and cellophaner, wrapping machine operator, poly- packer and heat sealer. He also testified that these jobs required no contact with the public. The ALJ asked the vocational expert if there was any discrepancy between his testimony and the Dictionary of Occupational Titles (DOT). The expert responded no.

THE ALJ'S DECISION

In her February 10, 2003 decision the ALJ concluded that plaintiff had severe impairments of major depression, anxiety disorder NOS, costochondritis, migraine headaches and polysubstance abuse that do not meet or medically equal any listed impairment. She specifically found that there was no evidence that plainitff ever met the C criteria of a mental impairment listing. The ALJ found that plainitff was not fully credible. In making this

finding the ALJ specifically addressed the factors in 20 CFR §§ 404.1529 and 416.929 and SSR 96-7p. She considered the medical evidence, plaintiff's daily activities, her poor work history, her medications, her use of illegal street drugs and evidence that she was receiving prescriptions for pain medications from multiple doctors.

The ALJ granted no weight to the opinion of Ms. Lumel that plaintiff had marked to extreme limitations in many areas of functioning. She found that Ms. Lumel was not an accepted medical source, her opinion was not supported by objective evidence and Dr. Butler testified that the assessment was inconsistent with objective evidence.

The ALJ also disregarded the opinion of the state agency medical reviewers who concluded that plaintiff could perform work at the medium exertional level. She gave great weight to the opinion of Dr. Butler, the medical expert, because it was well supported by the evidence.

The ALJ then found that plaintiff had the residual functional capacity to lift and carry 10 pounds frequently and 20 pounds occasionally; stand/walk six hours per eight-hour day and sit six hours per day, with the ability to change positions every 30 minutes; perform routine, repetitive work that is low stress in nature, without high production goals or rapid pace, with brief contact with others and work only in an alcohol and drug-free

environment with easy access to bathroom facilities. Based on the testimony of the vocational expert the ALJ found plaintiff could not perform her past relevant work but could perform work existing in significant numbers in the economy. The ALJ concluded that plaintiff was not disabled.

The ALJ made the following findings:

> 1. The claimant meets the nondisability requirements for a period of disability and Disability Insurance Benefits set forth in Section 216(I) of the Social Security Act an is insured for benefits through the date of this decision.
>
> 2. The claimant has engaged in substantial gainful activity since the alleged onset of disability.
>
> 3. The claimant has an impairment or a combination of impairments considered "severe" based on the requirements in the Regulations 20 CFR §§ 404.1520(b) and 416,920(b).
>
> 4. These medically determinable impairments do not meet or medically equal one of the listed impairments in Appendix 1, Subpart P, Regulations No. 4.
>
> 5. The undersigned finds the claimant's allegations regarding her limitations are not totally credible for the reasons set forth in the body of the decision.
>
> 6. The undersigned has carefully considered all of the medical opinions in the record regarding the severity of the claimant's impairments (20 CFR §§ 404.1527 and 416.927).
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> 7. The claimant has the following residual functional capacity: lift and carry 10 pounds frequently and 20 pounds occasionally, stand/walk six hours per eight-hour day and sit six hours per day, with the ability to

change positions every 30 minutes. The claimant can perform routine, repetitive work that is low stress in nature, without high production goals or rapid pace. The claimant can have only brief contact with others and can only work in an alcohol and drug-free environment. The claimant should have easy access to bathroom facilities.

8. The claimant is unable to perform any of her past relevant work (20 CFR §§ 404.1565 and 416.965).

9. The claimant is a "younger individual between the ages of 18 and 44." (20 CFR §§ 404.1563 and 416.963).

10. The claimant has a "high school (or high school equivalent) education." (20 CFR §§ 404.1564 and 416.964).

11. The claimant has no transferable skill from any past relevant work and/or transferability of skills is not an issue in this case (20 CFR §§ 404.1568 and 416.968).

12. The claimant has the residual functional capacity to perform a significant range of light work (20 CFR §416.967).

13. Although the claimant's exertional limitations do not allow her to perform the full range of light work, using Medical Vocational Rule 202.20 as a framework for decision-making, there are a significant number of jobs in the national economy that she could perform. Examples of such jobs include work as wrapper/packager (5,000 jobs in the regional economy) and folder/machine operator (2,100 jobs).

14. The claimant was not under a "disability," as defined in the Social Security Act, at any tome through the date of this decision (20 CFR §§ 1520(f) and 416.920(f).

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.

In her February 10, 2003 decision the ALJ concluded that plaintiff had severe impairments of major depression, anxiety disorder NOS, costochondritis, migraine headaches and polysubstance abuse that do not meet or medically equal any listed impairment.

She specifically found that there was no evidence that plainitff ever met the C criteria of a mental impairment listing. The ALJ found that plainitff was not fully credible. In making this finding the ALJ specifically addressed the factors in 20 CFR §§ 404.1529 and 416.929 and SSR 96-7p. She considered the medical evidence, plaintiff's daily activities, her poor work history, her medications, her use of illegal street drugs and evidence that she was receiving multiple prescriptions from multiple doctors.

The ALJ then found that plaintiff had the residual functional capacity to lift and carry 10 pounds frequently and 20 pounds occasionally; stand/walk six hours per eight-hour day and sit six hours per day, with the ability to change positions every 30 minutes; perform routine, repetitive work that is low stress in nature, without high production goals or rapid pace, with brief contact with others and work only in an alcohol and drug-free environment with easy access to bathroom facilities. Based on the testimony of the vocational expert the ALJ found plaintiff could not perform her past relevant work but could perform work existing in significant numbers in the economy. The ALJ concluded that plaintiff was not disabled.

RESIDUAL FUNCTIONAL CAPACITY ASSESSMENT

Plainitff argues that the ALJ's Residual Functional Capacity (RFC) finding omitted critical limitations. Plaintiff argues that the ALJ incorrectly disregarded Dr. Matkoms' notation on the Mental

RFC Assessment form that plaintiff had marked limitations in completing a normal work day and work week without interruptions. The ALJ is specifically instructed by the agency's Program Operations Manual System (POMS) that the "summary conclusions" portion of the Mental Impairment RFC Assessment Form are not to be used in determining the RFC because this portion of the form is merely a worksheet. Rather, the ALJ is to use Section III, Functional Capacity Assessment of the Mental RFC Assessment form. POMS 24510.060. In this section Dr. Matkom refers to p. 13 of the Psychiatric Review Technique Form that he completed.

The ALJ relied on Dr. Matkom's psychiatric Review Technique Form Section III Rating of Functional Limitations and his notes in Section IV to conclude that plainitff had only moderate limitations and could perform low stress routine work if she abstained from alcohol. The ALJ did not err by not using the Section I worksheet portion of the Mental RFC form in determining plaintiff's RFC finding.

Plaintiff argues that the ALJ did not properly include in his RFC assessment plaintiff's testimony that she could only sit for up to 30 minutes and then she would have to get up and move around including walking and stretch. The ALJ included this in his RFC assessment by finding that plaintiff needed to change position every thirty minutes. This limitation is consistent with plaintiff's testimony.

Plaintiff also contends that the ALJ did not properly evaluate her ability to handle work stress pursuant to SSR 85-15 which requires that any impairment related limitation created by an individual's response to demand of work must be reflected in the RFC assessment. The ALJ relied on the medical expert's testimony to determine that plaintiff could preform routine, repetitive work that is low stress in nature without high production goals or rapid pace.

Plaintiff, however, testified that her stress is caused by getting to work regularly and on time. There is no evidence in the record to support plaintiff's testimony and the ALJ properly disregarded it as not being fully credible. The ALJ properly evaluated plaintiff's ability to handle work stress.

Plaintiff further contends that the ALJ did not properly account for plaintiff's headaches in determining the RFC. There is no medical evidence to suggest that plaintiffs' headaches limited her RFC. The ALJ included all plaintiff's critical limitations in her assessment of plaintiff's Residual Functional Capacity.

CREDIBILITY

Plaintiff claims that the ALJ's credibility determination was erroneous. The ALJ's credibility decision must be upheld unless it is "patently wrong." Powers v. Apfel, 207 F.3d 421, 435 (7th Cir. 2000). Social Security Ruling 96-7p requires the ALJ to consider the claimant's daily activities, the duration, frequency and

intensity of the pain, precipitating and aggravating factors, the dosage, effectiveness and side effects of the medication and functional restrictions. 20 C.F.R. 404.1529(c).

The ALJ considered plaintiff's daily activities, medications and the medical evidence together with her poor work history, prescriptions from several doctors at the same time and her use of illegal drugs to find that her testimony considering her limitations was not fully credible. Plaintiff argues that the ALJ did not specify what portions of plaintiff's testimony she found not to be credible. The ALJ has presented her reasons for her credibility finding in the body of her decision. It can be inferred from these reasons that she found plaintiff's testimony concerning her inability to work at all because of stress and pain to not be credible. Based on the evidence in the record the Court cannot find that this credibility finding is patently wrong.

VOCATIONAL EXPERT TESTIMONY

Plaintiff contends that the ALJ's Step Five Finding is not supported by substantial evidence because the vocational expert's testimony was inconsistent with the DOT and the ALJ's RFC finding. In Prochaska v. Barnhart, 454 F.3d 731. 735-736 (7th Cir. 2006), the Court held that the ALJ had an affirmative duty to inquire about conflicts between the vocational expert testimony and the Dictionary of Occupational Titles (DOT) pursuant to SSR 00-4p. In

this case the ALJ complied with the SSR when she asked the expert whether his testimony was consistent with the DOT.

Plaintiff argues that even though the ALJ complied with the regulation the expert's testimony was not consistent with the DOT. First, she argues that the expert testified that plaintiff could perform the work of wrapping machine operator. According to the DOT this is medium work and plaintiff could only perform light work. Accordingly, plaintiff did not retain the residual functional capacity to perform this job. The expert, however, identified other jobs which exist in significant number in the economy that plaintiff could perform. Accordingly, his testimony was substantial evidence supporting the ALJ's finding that plaintiff could perform a significant number of jobs.

Second, plaintiff argues that the expert's testimony was not consistent with the ALJ's Residual functional capacity finding that plaintiff could have only brief contact with others in the work place. The expert testified that the jobs he listed which plaintiff could perform involved no contact with the public. This no contact with the public limitation was more restrictive than the ALJ's RFC finding which allowed brief contact with others. The DOT listings for folding machine operator, sewing machine operator, bander and cellophaner, poly-packer and heat sealer were consistent with the limitation of brief contact with supervisors and coworkers. The vocational expert's testimony was not inconsistent

with the ALJ's RFC finding that plaintiff could only have brief contact with others.

There is substantial evidence to support the Commissioner's finding that the plaintiff was not disabled because she could perform jobs existing in the national economy. Accordingly, the Commissioner's decision will be affirmed.

ORDER

IT IS ORDERED that plaintiff's motion to reverse the decision of the Commissioner is DENIED.

IT IS FURTHER ORDERED that the decision of the defendant Commissioner denying plaintiff Disability Insurance Benefits (DIB) is AFFIRMED.

Entered this 30th day of May, 2007.

BY THE COURT:

s/

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JOHN C. SHABAZ
District Judge