IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF IOWA
DAVENPORT DIVISION

CONNIE CONNER, Plaintiff, vs. MICHAEL J. ASTRUE, Commissioner of Social Security, Defendant.	3:07-cv-00040-JAJ **ORDER**

This matter comes before the court pursuant to briefs on the merits of Plaintiff Connie Conner's applications for disability insurance benefits and supplemental security income benefits. The final decision of the Commissioner of Social Security is remanded for further proceedings, consistent with this opinion.

I. PROCEDURAL BACKGROUND

Connie Conner applied for disability benefits on December 9, 2003, alleging an inability to work since November 4, 2003 (Tr. 50-52). Conner's application was denied initially, and on reconsideration (Tr. 23-25; 31-34). Allen requested a hearing by an Administrative Law Judge ("ALJ") (Tr. 33). A hearing before ALJ John E. Sandbothe was held on March 2, 2006 (Tr. 408-35). The ALJ denied Conner's appeal in a decision dated August 22, 2006 (Tr. 11-20). The Appeals Council denied Conner's request for review of the ALJ's decision on March 24, 2007 (Tr. 6-8). This action for judicial review was filed on May 3, 2007.

II. FACTUAL BACKGROUND

A. Medical History - Physical Health

Conner was hospitalized at the UIHC on April 15, 2003 following a suicide attempt, and remained hospitalized until May 6, 2003 (Tr. 159-84). Conner's discharge summary states, in pertinent part:

> **Cognitive deficit secondary to hypooxic brain injury.** The patient had neuropsych evaluation which showed she has a very well preserved common sense judgment with above-average superior memory. She had shrinking impairment of executive function as well as nonverbal ability associated with right hemisphere dysfunction.
>
> . . .
>
> **Chronic low back pain.** The patient had a previous x-ray which showed L4-5, L5-S1 degenerative disk disease. The patient did not have pain at the time of the night . . .
>
> . . .
>
> **Statement of Condition of Patient at the Time of Discharge:** . . . She markedly improved with minimal cognitive impairment. No low back pain at the time of discharge.

(Tr. 160-61).

Conner was again hospitalized at UIHC on November 28, 2003 when she underwent a left L5/S1 microdiskectomy for a herniated lumbar disk (Tr. 186-98). She was discharged on December 2, 2003 with instructions not to lift anything heavier than five pounds and avoid strenuous physical activity for six weeks, but otherwise have activity as tolerated (Tr. 186).

On February 5, 2004, Dr. T.J. Holub, D.C., Conner's treating chiropractor, offered the following opinion to Disability Determination Services:

> Connie Conner has been treated at our clinic for the past five years for recurring neck and back pain resulting from progressing degenerative arthritis and two herniated discs in her lumbar spine.
>
> Her response to treatment has been limited due to the disc condition. Her limitations should include no lifting heavier than ten pounds. No standing, sitting or walking for longer than 30 minutes before changing positions. No stooping, climbing or crawling. Kneeling permitted for no longer than five minutes. She should avoid traveling longer than 30 minutes by car.
>
> She is able to see, hear and speak.
>
> In conclusion, Connie's condition limits her from doing most activities of daily living (ADL) without suffering from acute flare-ups.

(Tr. 200-01).

On February 9, 2004, Conner was seen by Dr. Timothy Ryken of the UIHC Neurosurgery Department for follow-up from her back surgery (Tr. 299). Dr. Ryken's notes of this visit state:

> She says she has not required pain medication for approximately 2 weeks which is a good sign. In terms of her leg pain she does feel it is better. She continues with pain in her back, particularly down into the tail bone which she feels is related to a previous motor vehicle accident.

(Tr. 299).

Conner saw Dr. Mulder on October 27, 2004, with complaints of left leg, tailbone and shoulder pain (Tr. 291-92). Conner reported during this visit that she is unable to sit or stand for more than 30 minutes at a time due to her leg and tailbone pain (Tr. 291). Conner also reported weekly migraines (Tr. 291). Examination of her right shoulder showed a "limitation quite severe in both internal and external rotation of approximately

45 degrees" (Tr. 292). Dr. Mulder's impressions include chronic sacral and lower lumbar pain, frozen right shoulder, and migraine headaches (Tr. 292). Conner was given samples of Imitrex to use for her migraines (Tr. 292).

On November 9, 2004, Conner saw Dr. James V. Nepola of the UIHC Shoulder Clinic for evaluation of her shoulder pain (Tr. 287-90). Dr. Nepola's physical exam of Conner's shoulder showed that she was able to get to 165 degrees of elevation without difficulty (Tr. 289). She had positive impingement signs, no AC joint tenderness, 5/5 rotator cuff strength and is neurovascularly intact (Tr. 289). X-rays showed Grade II osteoarthritis of the right glenohumeral joint (Tr. 339). She was given an injection (Tr. 290).

Conner saw Dr. Mulder on November 22, 2004 (Tr. 285-86). Dr. Mulder's notes state: "I suspect that the majority of her sacroiliac pain is sacroiliac arthritis or more likely ligamentous strain and myofascial pain etiology. Patient has no evidence of hip joint involvement or sciatic nerve involvement." (Tr. 286). Dr. Mulder gave Conner his "blessing" to institute a "walking program to attempt to bring herself back into better health (Tr. 286). Dr. Mulder's notes also state that Conner has not had a migraine significant enough to need to use her Imitrex (Tr. 286).

On January 27, 2005, Conner saw Dr. Basem Hamid of the Center for Pain Management and Regional Anesthesia at UIHC (Tr. 282-84). Conner reported to Dr. Hamid that she could not sit for more than one hour due to her low back pain and that she was in the fourth day of a migraine headache (Tr. 282). Dr. Hamid's examination of Conner's back found "straight spine, no thoracic or lumbar paraspinal myofascial trigger points, normal thoracic kyphosis and normal lumbar lordosis" (Tr. 284). There was tenderness overlapping the right sacroiliac joint (Tr. 284). Conner had a normal range of motion and 5/5 motor strength throughout. She had normal muscle tone and diffuse muscle pain (Tr. 284). Dr. Hamid's impressions were:

> 1. Chronic musculoskeletal low back pain. I agree that the majority of her sacroiliac pain is likely ligamentous strain and myofascial pain etiology secondary to deconditioning.
> 2. Cephalgia.
> 3. Right subacromial bursitis.
> 4. Osteoarthritis, right hip.

(Tr. 284).

On February 14, 2005, Conner saw Dr. Mulder complaining of, among other things, chronic pain and migraines (Tr. 277). Dr. Mulder noted that Conner's headaches "seem to be stress induced." (Tr. 278).

On March 8, 2005, Conner saw Dr. Nepola for continued evaluation of her shoulder pain (Tr. 275). Conner had received a subacromial injection in her shoulder in November 2004 which gave her a moderate amount of pain relief (Tr. 275). A repeat injection in February 2005 provided Conner no relief (Tr. 275). Dr. Nepola notes of his physical examination of Conner state, in relevant part:

> Examination of her right upper extremity demonstrates the patient to have tenderness to palpation both anterior and posterior in generalized region about the shoulder. She has positive Neer sign and positive Hawkins sign. She has slight weakness to external rotation. The patient seems to be squinting some secondary to pain.

(Tr. 275). Dr. Nepola diagnosed Conner with impingement syndrome of her shoulder and gave her a subacromial injection (Tr. 276).

Conner saw Dr. Mulder on August 22, 2005, for reassessment of joint pain and headaches (Tr. 269). At this visit Conner reported an increased frequency of migraines, up to approximately two per week (Tr. 269). The physical examination of Conner's right shoulder "shows fairly impressive limitations with only about 45 degrees of external rotation, 60 degrees of abduction, and 90 decrees of internal rotation" (Tr. 269). The range of motion of her left shoulder was "basically normal." (Tr. 269). Conner was prescribed medication for her migraines and found to have both impingement syndrome

and osteoarthritis in her right shoulder (Tr. 270). Her pain medication was changed to Naprosyn (Tr. 270). Conner also saw Dr. Mulder with complaints of joint pain and migraine headaches on June 6, 2005 (Tr. 271). Her physical examination showed no joint crepitance and full range of motion of both shoulders (Tr. 272).

B. Medical History - Mental Health

Conner underwent psychotherapy at the Community Mental Health Center for Mid-Eastern Iowa from May 19, 2003 through August 4, 2003, and again from March 4, 2004 through June 15, 2004 (Tr. 229-42). During 2003, Conner treated with Dr. Mary Hanna, Ph.D. (Tr. 239-41). In 2004, Conner treated with Susan Totten, L.M.S.W. and Dr. William Stutts, D.O. (Tr. 229-38; 263-66). Dr. Stutts' notes of his May 14, 2004, diagnostic evaluation state, in pertinent part:

> She is alert, fully oriented, well dressed and groomed. She does not look as if she has been living out of her car. Her affect is full and bright. Mood is slightly depressed. She is quite talkative. Speech is spontaneous, regular, goal directed and quite interactive. Thought processes are logical and organized. There is no evidence of lethality or psychosis. Intelligence appears average and cognitive functioning appears within normal limits despite some reports of brain damage. Insight and judgment appear fair.

(Tr. 266).

At her June 8, 2004 visit, Conner reported that she was suffering from a migraine and left leg pain (Tr. 230). In a letter dated November 11, 2004, Ms. Totten states:

> Connie Conner has been seeing me for counseling at the Community Mental Health Center for Mid-Eastern Iowa in Iowa City since 3/04/04. Connie has not been able to work since we have been working with each other due to both mental and physical difficulties. It is my opinion that she would have extreme difficulty being employed full time or supporting herself independently.

(Tr. 243).

Conner underwent counseling at the Washington County Mental Health Center from December 16, 2004 to August 22, 2005 (Tr. 360-78). During this time, Conner regularly met with Ms. Jeanette Miller, L.M.S.W. The treatment notes reflect Conner's fear of being around other people and having panic attacks. At her April 15, 2005 visit, Conner reported that she had not bathed or washed her hair for two weeks, as she spends most of her time in bed and does not want to go out or see people (Tr. 366). At her April 29, 2005 visit, Conner reported that she had typed up her memoirs and is ready to send it to magazines, hoping for publication (Tr. 365). Ms. Miller's notes of May 19, 2005, state: "It doesn't seem impossible that she could, eventually, get at least a part-time job to pay for essentials." (Tr. 364). At her June 2, 2005 visit, Conner reported that she would love to go back to work, but "hates to be around people." (Tr. 363).

On October 13, 2005, Ms. Miller completed a "Medical Source Statement of Ability to do Work-Related Activities (Mental)" (Tr. 379-80). Ms. Miller opines that Conner was moderately limited in her ability to remember short, simple instructions, carry out short, simple instructions, understand and remember detailed instructions, carry out detailed instructions, and make judgments on simple work-related decisions (Tr. 379). In support of these limitations, Ms. Miller notes Conner's diagnosis of panic disorder with agoraphobia and states that Conner left her last job because of panic attacks (Tr. 379). Ms. Miller further opined that Conner was markedly limited in her ability to interact appropriately with the public, supervisors, co-workers, and in her ability to respond appropriately to work pressures in a usual work setting. Ms. Miller opined that Conner was moderately limited in her ability to respond appropriately to changes in a routine work setting (Tr. 379).

C. Vocational Rehabilitation

Conner began receiving vocational rehabilitation services on May 27, 2004 (Tr. 154-55). After several visits, Conner agreed to a facility to participate in a facility work

site assessment to assess her abilities, limitations and restrictions (Tr. 150). A follow-up neuropsychological examination was also scheduled (Tr. 150). The work site assessment was scheduled for January 24, 2005 (Tr. 149). At a February 23, 2005 meeting with her vocational rehabilitation counselor, Conner reported that she was only able to work three half-days of her work site assessment and was unable to continue because of migraines she suffered from the stress and being around so many people with disabilities (Tr.149). The notes of this meeting state: "Connie states ideally she would like to work 15-20 hours per week 4 hours a day and it be something where she could sit or stand as needed during different parts of the day." (Tr. 149). A community work site assessment for Conner was scheduled for April 4, 2005 (Tr. 149). Conner never showed up for this assessment, calling in the first week complaining of migraine headaches, and not calling at all after that (Tr. 147). On April 18, 2005, Conner wrote a letter to her vocational rehabilitation counselor advising that she did not attend the assessment due to mental health problems she had (Tr. 146, 147). Conner further advised that she did not feel that she was capable of working, so her vocational rehabilitation case file was closed (Tr. 145).

D. Consultative Examinations

Dr. John A. May, M.D., completed a Physical Residual Functional Capacity Assessment of Conner on February 19, 2004 (Tr. 206-11). Dr. May opined that Conner could occasionally lift and/or carry 20 pounds, frequently lift and/or carry 10 pounds, stand and/or walk about six hours in an eight-hour workday, sit about six hours in an eight-hour workday, and was unlimited in her ability to push and/or pull (Tr. 207). In support of these findings, Dr. May notes that the follow-up records from Conner's diskectomy showed no complications and indicated that, as of February 9, 2004, Conner had not taken any pain medication for two weeks (Tr. 207). Dr. May further opined that Conner could occasionally climb ramps/stairs, never climb ladders/ropes/scaffolds, but could occasionally balance, stoop, kneel, crouch and crawl (Tr. 208). Dr. May found no

manipulative, visual or communicative limitations (Tr. 208-09). Dr. May opined that Conner should avoid concentrated exposure to vibration and hazards, but had no other environmental limitations (Tr. 209). Dr. Libbie J.Russo, M.D. agreed with Dr. May's findings, noting that, with respect to Conner's alleged inability to sit more than 30 minutes, no medical or psychological source ever observed Conner to have difficulty sitting through the numerous personality tests, physical exams and interviews (Tr. 204). Dr. Russo further noted that Conner had not complained to any treating sources regarding her limited sitting ability (Tr. 204). On August 24, 2004, Dr. Claude H. Koons, M.D., reviewed Dr. May's assessment and affirmed it as written (Tr. 211). Dr.Koons' notes state that Conner was off of narcotics as of her June 18, 2004 visit, "doing better," and had regained power in her lower extremities (Tr. 212).

On February 19, 2004, Dr. John C. Garfield, Ph.D., completed a Psychiatric Review Technique of Conner (Tr. 213-27). Dr. Garfield opined that Conner was mildly limited in her activities of daily living, mildly limited in maintaining social functioning, mildly limited in maintaining concentration, persistence, or pace, and had no episodes of decompensation of extended duration (Tr. 223).

Dr. Lon Olsen, Ph.D., completed a Mental Residual Functional Capacity Assessment and Psychiatric Review Technique of Conner on July 30, 2004 (Tr. 244-61). Dr. Olsen opined that Conner was not significantly limited in her understanding and memory and sustained concentration and persistence (Tr. 244-45). Dr. Olsen opined that Conner was moderately limited in her ability to interact appropriately with the general public, accept instructions and respond appropriately to criticism from supervisors, get along with coworkers or peers without distracting them or exhibiting behavioral extremes, respond appropriately to changes in the work setting, and travel in unfamiliar places (Tr. 245). Otherwise, Dr. Olsen found that Conner was not significantly limited with respect to social interaction and adaption (Tr. 245). In support of his conclusions, Dr. Olsen noted

that Conner showed no evidence of ongoing neuropsychological impairment at subsequent appointments for her physical conditions, but rather provided well-organized and highly detailed information regarding her activities of daily living (Tr. 246). Dr. Olsen further noted that Conner did not pursue mental health treatment until May 2004, and that Conner is independent for all self-cares, performs some daily activities, maintains at least superficial social relationships, and engages in purposeful activity when motivated to do so (Tr. 246). On her Psychiatric Review Technique, Dr. Olsen opined that Conner was mildly restricted in her activities of daily living and had mild difficulties in maintaining concentration, persistence, or pace (Tr. 258). Dr. Olsen opined that Olsen had moderate difficulty in maintaining social functioning, and no episodes of decompensation, each of extended duration (Tr. 258).

On January 24, 2005 Conner was evaluated by Dr. Roger E. Mraz, Ph.D., on referral from her vocational rehabilitation counselor (Tr. 383-85). Dr. Mraz's report states that Conner's goal is to do some kind of work out of her home (Tr. 383). Conner reported as part of this evaluation that she experiences approximately two migraine headaches per month (Tr. 383). In summary, Dr. Mraz found:

> The current results suggest that Connie has made significant gains in her cognitive functioning. She now scores in the Average Range of intelligence; at the 37th percentile. Verbal comprehension skills and perceptual organization skills were both found to be in the Average Range. Connie did have difficulty with mental computations, but her Working Memory Index score was in the Average Range, at the 30th percentile. Other than her reluctance to attempt mental computations and her slow pace in processing visual information, I did not find any cognitive impairments that would impact negatively on future training or her employability.

(Tr. 384-85).

On October 17, 2006, Dr. Mulder, Conner's long-term treating physician, completed a Medical Assessment of Ability to do Work-Related Physical Activities (Tr.

405-07). Dr. Mulder opined that Conner could lift 20 pounds occasionally, 10 pounds frequently, and carry 10 pounds occasionally and frequently (Tr. 405). In explaining his opinion, Dr. Mulder stated that Conner "can barely lift 6-pk of soda with both hands" (Tr. 405). Dr. Mulder opined that Conner could sit for two and-a-half hours at one time and then needs to walk about, away from the workstation (Tr. 405). Dr. Mulder opined that Conner could sit five to six hours total during an eight-hour workday (Tr. 405). In explaining these opinions, Dr. Mulder relies on Conner's estimates (Tr. 405). Dr. Mulder opined that Conner can stand and walk for one hour before she needs to lie down or recline, and that she can stand and walk a total of four hours in an eight-hour workday (Tr. 406). Dr. Mulder opined that Conner had "normal hand use" and could frequently reach, handle and finger (Tr. 406). Dr. Mulder opined that Conner would need to take three to four one-hour breaks (Tr. 407). In support of these opinions, Dr. Mulder cites to x-rays which document right shoulder bone spurs and bone spurs of the entire lumbar spine (Tr. 407). Dr. Mulder further cites to a June 27, 2006, finding of bilateral shoulder impingement syndrome, and notes that anxiety limits Conner's ability to interact regularly (Tr. 407).

E. Hearing Testimony

In describing her job duties at American College Testing (ACT), Conner testified that she collated reports, put the reports in order, proofread the reports, checked for smudges, and then packaged the materials for mailing (Tr. 412). At most she had to lift 30 to 40 pounds on this job, and frequently lifted at least up to 20 pounds (Tr. 412). Conner also worked part time (four hours per day) for approximately three or four months doing data entry at National Computer Systems (NCS) (Tr. 412, 413). Conner estimated her typing speed to be 20 words per minute or less (Tr. 414).

Conner testified that she actually became disabled approximately two weeks before her alleged onset date of November 4, 2003 (Tr. 414). Conner testified that she

experienced a severe pain in her back which radiated down her leg within a few days and progressed to the point that she could not walk (Tr. 414). Conner testified that she still has severe pain in her back, neck and right shoulder on a daily basis (Tr. 415). Conner testified that her December 2003 back surgery helped, but that her back pain has never gone away completely (Tr. 416). Conner testified that the pain sometimes radiates to her tail bone, which makes it very hard for her to sit for any length of time (Tr. 416). Housework makes her back pain worse and grocery shopping is only done with a severe amount of pain (Tr. 416).

With respect to her shoulder pain, Conner testified that the injections she received did not help (Tr. 418). Conner further testified that her neck, shoulder and back ache if she sits at her computer for maybe an hour (Tr. 419). Conner testified that she cannot stand in one position for more than 20 to30 minutes and could not stand or walk for more than an hour (Tr. 420). Conner testified that, if she was able to get up and move around, she could sit a total of three hours in an eight-hour day (Tr. 420). Conner testified that she cannot bend at the waist and that she has trouble stooping (Tr. 420). Conner testified that she can lift no more than a 12-pack of pop (Tr. 420).

At the time of the hearing, Conner was not seeing a psychiatrist and was not on any psychiatric medication (Tr. 421). She was seeing a therapist for her severe depression (Tr. 422). Conner testified that, maybe once per month, there are days where she does not get out of bed, bathe, or take care of her house, and these episodes may last for a week (Tr. 422). Conner testified that if she is in a room with more than two or three people, she gets shaky, feels like she is going to throw up and feels like she cannot breathe (Tr. 423). Conner testified that she cannot concentrate when she feels really depressed and that she is very short-tempered with people (Tr. 423). Conner has never taken any antidepressant medication because she does not believe in it (Tr. 424).

In describing a typical day, Conner testified that she never sleeps more than three or four hours per night (Tr. 424). She spends her days reading, watching television, and sometimes doing some hand sewing (Tr. 424). Upon waking up, she washes her dishes from the night before, has a cup of hot tea, and goes to the community building at her apartment complex for coffee approximately once per week (Tr. 425, 426). She testified that she spends most of the day lying down, and may take a short, four-block walk in the afternoons (Tr. 425).

Conner testified that she was not currently taking any pain medication because she could not afford to have her prescriptions refilled (Tr. 427). Conner testified that she has migraine headaches at least two times per week, each lasting anywhere from four to six hours to two or three days (Tr. 429). She has been prescribed medication for her migraine headaches, but again cannot afford to get it (Tr. 430).

The ALJ posed the following hypothetical question to the vocational expert:

> This would be currently a 53-year-old woman with a GED, past work as noted in 17E. Been diagnosed with degenerative disk disease, status post diskectomy, depression, complains of migraines and complains of shoulder pain . . . She could lift 20 pounds occasionally, ten pounds frequently. She should only occasionally balance, stoop, crouch, kneel, crawl or climb. No hazards, no vibrations. Only occasional shallow contact with the public and no more than regular pace. With those limits, past work?

The vocational expert responded that, under that hypothetical scenario, Conner would be able to do her previous jobs as data entry clerk and clerk, general. (Tr. 431).

The ALJ then posed a second hypothetical question to the vocational expert, i.e.:

> The same vocational and medical backgrounds as for, the same limitations as before. However, I am going to add that she can't stand or walk more than two hours total during a work day and she is going to require two or more absences per month. With those additional limitations, competitively employable?

The vocational expert responded "No." (Tr. 432).

Conner's attorney had the following exchange with the vocational expert and ALJ: Atty: If we were to take the first hypothetical and add the following mental limitation. She has moderate limitations in her ability to understand, remember and carry out instructions, marked limitations in her ability to understand, remember and carry out instructions, marked limitations in her ability to interact with others in the workplace and to respond appropriately to work pressures at a usual work site.

> **ALJ**: Such that she might require a slow pace for say one-third of the day?
> **ATTY**: No. I don't that this would necessarily affect her pace. She just doesn't remember instructions moderately well, but she has marked - - she has a lot of difficulty interacting with others.
> **ALJ**: Okay.
> **ATTY**: Marked limitations in responding appropriately to work pressures, she has testified she gets angry easily.
> **ALJ**: Okay.
> **VE**: I still think that she could do the clerk job. It's semiskilled and really has a low level of . . . interaction.

(Tr. 433).

III. CONCLUSIONS OF LAW

A. Scope of Review

In order for the court to affirm the ALJ's findings of fact, those findings must be supported by substantial evidence appearing in the record as a whole. See Lochner v. Sullivan, 968 F.2d 725, 727 (8th Cir. 1992); Cruse v. Bowen, 867 F.2d 1183, 1184 (8th Cir. 1989). Substantial evidence is more than a mere scintilla. It means relevant evidence a reasonable mind might accept as adequate to support a conclusion. Richardson v. Perales, 402 U.S. 389, 401 (1997); Cruse, 867 F.2d at 1184; Taylor v. Bowen, 805 F.2d

329, 331 (8th Cir. 1986). The court must take into account evidence that fairly detracts from the ALJ's findings. Cruse, 867 F.2d at 1184; Hall v. Bowen, 830 F.2d 906, 911 (8th Cir. 1987). Substantial evidence requires "something less than the weight of the evidence, and the possibility of drawing two inconsistent conclusions from the evidence does not prevent an administrative agency's findings from being supported by substantial evidence."). Cruse, 867 F.2d at 1184 (quoting Consolo v. Fed. Mar. Comm'n, 383 U.S. 607, 620 (1966)). The court must consider the weight of the evidence appearing in the record and apply a balancing test to contradictory evidence. Gunnels v. Bowen, 867 F.2d 1121, 1124 (8th Cir. 1989); Gavin v. Heckler, 811 F.2d 1195, 1199 (8th Cir. 1987).

B. ALJ's Disability Determination

Determining whether a claimant is disabled involves a five-step evaluation. See 20 C.F.R. § 404.1520(a)–(f); Bowen v. Yuckert, 482 U.S. 137, 140 (1987).

The five steps are:

> (1) If the claimant is engaged in substantial gainful activity, disability benefits are denied.
>
> (2) If the claimant is not engaged in substantial gainful activity, her medical condition is evaluated to determine whether her impairment, or combination of impairments, is medically severe. If the impairment is not severe, benefits are denied.
>
> (3) If the impairment is severe, it is compared with the listed impairments the Secretary acknowledges as precluding substantial gainful activity. If the impairment is equivalent to one of the listed impairments, the claimant is disabled.
>
> (4) If there is no conclusive determination of severe impairment, then the Secretary determines whether the claimant is prevented from performing the work she performed in the past. If the claimant is able to perform her previous work, she is not disabled.

> (5) If the claimant cannot do her previous work, the Secretary must determine whether she is able to perform other work in the national economy given her age, education, and work experience.

Trenary v. Bowen, 898 F.2d 1361, 1364 n.3 (8th Cir. 1990) (citing Yuckert, 482 U.S. at 140–42); 20 C.F.R. § 404.1520(a)–(f).

"To establish a disability claim, the claimant bears the initial burden of proof to show that he is unable to perform his past relevant work." Frankl v. Shalala, 47 F.3d 935, 937 (8th Cir. 1995) (citing Reed v. Sullivan, 988 F.2d 812, 815 (8th Cir. 1993)). If the claimant meets this burden, the burden of proof then shifts to the Commissioner to demonstrate that the claimant retains the physical residual functional capacity (RFC) to perform a significant number of other jobs in the national economy that are consistent with the claimant's impairments and vocational factors such as age, education and work experience. Id.

Under the first step of the analysis, the ALJ found that Conner had not engaged in substantial gainful activity since November 4, 2003, the alleged onset date (Tr. 15). At the second step, the ALJ determined that Conner has the following severe impairments: degenerative disc disease with a history of diskectomy, depression, complaints of migraine headaches and complaints of shoulder pain (Tr. 15). At the third step, the ALJ found that Conner did not have an impairment or combination of impairments that meets or medically equals a listed impairment (Tr. 18). Proceeding to the fourth step, the ALJ determined that Conner was able to perform her past relevant work as a data entry clerk, both as normally performed and as actually performed, and as a general clerk as normally performed (Tr. 19). Therefore, the ALJ found that Conner was not disabled within the meaning of the Social Security Act at any time through the date of the decision (Tr. 20).

C. Residual Functional Capacity

Conner argues that the ALJ erred in failing to include all of her restrictions in his residual functional capacity assessment. First, Conner argues that the ALJ wrongly rejected her testimony that she was unable to stand or walk for any extended period of time and did not take into account Dr. Mulder's report[1] specifying that Conner was limited in her standing and walking to no more than four hours per day for no more than one hour at a time. Dr. Mulder also advised that Conner would need to be able to rest during the day, either by lying down or in a recliner. Conner also points to a statement by the ALJ that her back pain must have abated after her June 18, 2004 doctor visit because there was a lack of subsequent medical treatment, arguing that such statement is factually incorrect as the records reflect that she continued to receive treatment for her low back pain from Dr. Mulder and the UIHC pain clinic. Second, Conner argues that her shoulder restrictions were not properly reflected in the ALJ's RFC. Third, Conner contends that the ALJ erred in including no restrictions relating to her migraines in determining her RFC. Finally, Conner claims that the ALJ's finding that she "could tolerate occasional, superficial contact with the public" is not supported by any evidence in the record, which actually leads to the conclusion that Conner is unable to tolerate regular contact with other people without exacerbating her mental health symptoms.

The defendant resists, arguing that the ALJ properly determined Conner's RFC, noting that the treatment notes did not portray Conner as a person who suffered from the extreme limitations she claimed.

The ALJ found that Conner possessed the following RFC:

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[1]Conner concedes that Dr. Mulder's October 2006 report was not available to the ALJ when he made his August 2006 decision. Dr. Mulder's report was produced to the Appeals Council. Now taking it into consideration, the court must determine whether the record as a whole, including the new evidence, supports the ALJ's determination. Cunningham v. Apfel, 222 F.3d 496, 500 (8th Cir. 2000).

> After careful consideration of the entire record, the undersigned finds that the claimant has the residual functional capacity to lift 20 pounds occasionally and 10 pounds frequently. She can balance, stoop, crouch, kneel, crawl and climb occasionally. She must avoid hazards and excessive vibrations. She can tolerate occasional, superficial contact with the public. Finally, she can work at a regular pace but not at a fast pace.

(Tr. 18).

In so finding, the ALJ noted that Conner visits the community center in her apartment complex to drink coffee from time to time for about 30 minutes, and that there were usually around six people there. Further, the ALJ discounted the opinion of Conner's chiropractor as inconsistent with the other medical evidence of record. The ALJ noted that the medical records failed to show any changes, such as muscle atrophy, preventing Conner from carrying objects weighing more than 10 pounds. The ALJ further noted that Conner had undergone intelligence testing, which required her to sit for more than 30 minutes, and there was no indication that she had to change positions while doing so. The ALJ relied on the fact that Conner "has also been able to live in her car, an unpleasant circumstance that would require her to remain in uncomfortable positions for extended periods while sleeping." (Tr. 18). Conner's physical RFC, as found by the ALJ, was consistent with the opinions of consultative examiners Drs. Russo and May, and her mental limitations were consistent with the opinions of Dr. Olsen. The ALJ gave the opinion of Dr. Olsen greater weight than that of Jeanette Miller, noting that Olsen is an "acceptable medical source," even though he is a reviewing, but non-treating source.

Determining a claimant's residual functional capacity is a medical question. Lauer v. Apfel, 245 F.3d 700 (8th Cir. 2001); Singh v. Apfel, 222 F.3d 448, 451 (8th Cir. 2000). "The Commissioner must determine a claimant's RFC based on all of the relevant evidence, including the medical records, observations of treating physicians and others, and an individual's own description of his limitations." McGivney v. Apfel, 228 F.3d

860, 863 (8th Cir. 2000) (citing Anderson v. Shalala, 51 F.3d 777, 779 (8th Cir. 1995)). However, the record "must include some medical evidence that supports the ALJ's residual functional capacity finding." Dykes v. Apfel, 223 F.3d 865, 867 (8th Cir. 2000) (citing Anderson, 51 F.3d at 779); Lauer, 245 F.3d at 704 (noting that while the ALJ was not "limited to considering medical evidence," the ALJ was "required to consider at least some supporting evidence from a professional."). "The opinions of doctors who have not examined the claimant ordinarily do not constitute substantial evidence on the record as a whole." Nevland v. Apfel, 204 F.3d 853, 858 (8th Cir. 2000). Further, an ALJ "may not draw upon his own inferences from medical reports." Lund v. Weinberger, 520 F.2d 782, 785 (8th Cir. 1975). "If the ALJ did not believe, moreover, that the professional opinions available to him were sufficient to allow him to form an opinion, he should have further developed the record to determine, based on substantial evidence, the degree to which [the claimant's] mental impairments limited his ability to engage in work-related activities." Lauer, 245 F.3d at 706 (citing Nevland, 204 F.3d at 858; 20 C.F.R. § 404.1519a(b)).

On August 9, 2006, the Social Security Administration (SSA) issued Social Security Ruling (SSR) 06-3p, which clarified how it considers opinions from sources who are not what the agency terms "acceptable medical sources." 71 Fed. Reg. 45,593. Under SSA regulations, "acceptable medical sources" include licensed physicians, licensed or certified psychologists, licensed optometrists, licensed podiatrists, and qualified speed-language pathologists. See 20 C.F.R. §§ 404.1513(a) and 416.913(a). Only "acceptable medical sources" can provide evidence to establish the existence of a medically determinable impairment, provide medical opinions, and be considered treating sources, whose opinions may be entitled to controlling weight. See 20 C.F.R. §§ 404.1513(a), 404.1527(a)(2), 416.927(a)(2), 404.1502, 416.902, 404.1527(d), and 416.927(d).

Information from "other sources," as defined in 20 C.F.R. §404.1513(d) and 416.913(d) may be used to demonstrate the severity of the individual's impairment(s) and how it affects an individual's ability to function. 71 Fed. Reg. 45,593 *45,594. These sources include, but are not limited to licensed clinical social workers, chiropractors and therapists. Id.

> Information from these "other sources" cannot establish the existence of a medically determinable impairment. Instead, there must be evidence from an "acceptable medical source" for this purpose. However, information from such "other sources" may be based on special knowledge of the individual and may provide insight into the severity of the impairment(s) and how it affects the individual's ability to function.

Id.

Factors to consider in considering opinion from "other sources" include:

- How long the source has known and how frequently the source has seen the individual;
- How consistent the opinion is with other evidence;
- The degree to which the source presents relevant evidence to support an opinion;
- How well the source explains the opinion;
- Whether the source has a specialty or area of expertise related to the individual's impairment(s); and
- Any other factors that tend to support or refute the opinion.

Id. at 45,595.

> Opinions from "other medical sources" may reflect the source's judgment about some of the same issues addressed in medical opinions from "acceptable medical sources," including symptoms, diagnosis and prognosis, what the individual can

still do despite the impairment(s), and physical and mental restrictions.

Not every factor for weighing opinion evidence will apply in every case. The evaluation of an opinion from a medical source who is not an "acceptable medical source" depends on the particular facts in each case. Each case must be adjudicated on its own merits based on a consideration of the probative value of the opinions and a weighing of all the evidence in that particular case.

The fact that a medical opinion is from an "acceptable medical opinion" is a factor that may justify giving that opinion greater weight than an opinion from a medical source who is not an "acceptable medical source" because, as we previously indicated in the preamble to our regulations at 65 FR 34955, dated June 1, 2000, "acceptable medical sources" "are the most qualified health care professionals." However, depending on the particular facts in a case, and after applying the factors and weighing opinion evidence, an opinion from a medical source who is not an "acceptable medical source" may outweigh the opinion of an "acceptable medical source," including the medical opinion of a treating source.

. . .

Since there is a requirement to consider all relevant evidence in an individual's case record, the case record should reflect the consideration of opinions from medical sources who are not "acceptable medical sources" and from "non-medical sources" who have seen the claimant in their professional capacity. Although there is a distinction between what an adjudicator must consider and what the adjudicator must explain in the disability determination or decision, the adjudicator generally should explain the weight given to opinions from these "other sources," or otherwise ensure that the discussion of the evidence in the determination or decision allows a claimant or subsequent reviewer to follow the

> adjudicator's reasoning, when such opinions may have an effect on the outcome of the case.

Id. at 45,595-6.

The ALJ's decision states that he considered "opinion evidence in accordance with the requirements of 20 C.F.R. 404.1527 and 416.927 and SSRs 96-2p, 96-5p and 96-6p." (Tr. 18). Perhaps the ALJ was not aware of SSR 06-09p, which was enacted just 13 days prior to his opinion. Conner saw Ms. Miller on a regular basis from December 2004 through August 2005. The length and frequency of Conner's treatment relationship with Ms. Miller weigh in favor of affording Miller's opinion more weight than afforded by the ALJ. Moreover, the ALJ's rationale for giving Dr. Olsen's opinion more weight than Ms. Miller's simply because he is an "acceptable medical source"and Ms. Miller is not, is hardly a "discussion of the evidence in the determination or decision which allows a claimant or subsequent reviewer to follow the adjudicator's reasoning." SSR 06-3p. Remand is appropriate so that the ALJ can evaluate the opinion of Ms. Miller under SSR 06-3p. The ALJ shall also consider the opinion of Dr. Holub, Conner's chiropractor, in accordance with SSR 06-3p.

On remand, the ALJ shall also duly consider the October 17, 2006, opinion of Conner's long-time treating physician, Dr. Mulder. "A treating physician's opinion should not ordinarily be disregarded and is entitled to substantial weight. A treating physician's opinion regarding an applicant's impairment will be granted controlling weight, provided the opinion is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the record." Singh v. Apfel, 222 F.3d 448, 452 (8th Cir. 2000) (citation omitted). The regulations require the ALJ to give reasons for giving weight to or rejecting the statements of a treating physician. See 20 C.F.R. § 404.1527(d)(2). Whether the ALJ gives great or small weight to the opinions of treating physicians, the ALJ must give good reasons for giving the opinions that weight. Holmstrom v. Massanari, 270 F.3d 715, 720 (8th Cir. 2001). "The

ALJ may discount or disregard such an opinion if other medical assessments are supported by superior medical evidence, or if the treating physician has offered inconsistent opinions." Hogan v. Apfel, 239 F.3d 958, 961 (8th Cir. 2001). Moreover, a treating physician's opinion does not deserve controlling weight when it is nothing more than a conclusory statement. Piepgras v. Chater, 76 F.3d 223, 236 (8th Cir. 1996). See also Thomas v. Sullivan, 928 F.2d 255, 259 (8th Cir. 1991) (holding that the weight given a treating physician's opinion is limited if the opinion consists only of conclusory statements).

Upon the foregoing,

IT IS ORDERED that the decision of the ALJ is reversed and remanded for further proceedings, consistent with this opinion. The Clerk of Court shall enter judgment accordingly.

DATED this 30th day of September, 2008.

JOHN A. JARVEY
UNITED STATES DISTRICT JUDGE
SOUTHERN DISTRICT OF IOWA