

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

MARCIA C. TORRUELLA,

Plaintiffs,

vs.

MICHAEL J. ASTRUE,  
Commissioner of Social Security,

Defendant.

No. 4:07-cv-0233-JAJ

**ORDER**

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This matter comes before the court pursuant to briefs on the merits of this application for disability insurance benefits. This court finds that the decision of the Social Security Administration is not supported by substantial evidence. The case is reversed for an award of benefits.

**I. PROCEDURAL BACKGROUND**

Plaintiff Marcia Collins Torruella (“Torruella”) filed an application for Title II Disability Insurance Benefits (“DIB”) on February 24, 2004, and for Title XVI Supplemental Security Income (“SSI”) on December 3, 2004. She alleged an inability to work from August 1, 1995. She later amended that date to March 1, 1998. The Social Security Administration (“SSA”) denied Torruella’s application initially and again upon reconsideration. Administrative Law Judge (“ALJ”) W. Howard O’Bryan, Jr., held a hearing on Torruella’s claim on May 1, 2006 (Tr. 364-91). The ALJ found that Torruella was disabled from August 9, 2004, but not disabled prior to her Date Last Insured (“DLI”), December 31, 1998. The ALJ therefore denied Torruella’s Title II DIB claim, but found that she was eligible for SSI from August 9, 2004 onward. Torruella appealed the denial of her DIB to the SSA Appeals Council on July 28, 2006. The Appeals Council denied Torruella’s petition for review on April 3, 2007. She filed the present request for review on June 2, 2007 (dkt. no. 1).

## **II. FACTUAL BACKGROUND**

At the time of the hearing, Torruella was forty-eight years old. She was forty at the time of her alleged disability onset date. Torruella completed high school and one year of college. Her vocationally relevant work experience is work as a operation room technician.

### **A. Relevant Medical History**

Torruella's medical record shows she has had numerous medical problems from around 1995 until present. Her most significant medical condition was diagnosed in January 2004, when a neurologist found a grapefruit-sized brain tumor, which was removed two weeks later. It was this medical impairment that was the basis for the ALJ's disability determination, for which she receives SSI benefits.

Torruella asks this court to review the findings regarding her disability for a time period long before her brain tumor was discovered. Starting around 1995, Torruella suffered from depression and bipolar disorder. Based on these impairments, she sought DIB. The issue on appeal is whether she was disabled between her amended onset date, March 1, 1998, and her DLI, December 31, 1998. Thus, the court will only discuss the medical history leading up to this period, even though the record includes medical records for many years after that date. The court will also only discuss her treatment related to depression and bipolar disorder, even though she had myriad other health problems.

From November 2, 1994, to April 29, 2002, Torruella saw Palma Wideman, M.D., for treatment of menopausal symptoms, hypertension, headaches, allergies, obesity, tremors, and lower extremity edema. On September 7, 1995, Dr. Wideman wrote that Torruella was having difficulty dealing with her mother's death a few months earlier. Torruella told her that a couple of weeks earlier she had "spent [the] whole week crying – couldn't stop." She was also having difficulty sleeping. Dr. Wideman diagnosed her with prolonged grief, DSM IV 309.1, and prescribed Prozac.

On April 26, 1996, Torruella called Dr. Wideman's office asking if Dr. Wideman could increase her Prozac because she woke up that morning and did not recognize her husband.

On August 29, 1996, Torruella was admitted to the emergency room at Sutter Auburn Faith Hospital after her husband called 911, reporting an overdose of Xanax and Prozac. The treatment notes indicate that she was depressed and suicidal at that time. She was transferred to Charter Behavioral Health System for psychiatric evaluation and treatment. Her attending psychiatrist, Dr. Dwight O. Swaback, indicated that she had Major depression and a GAF of 25. Torruella told Dr. Swaback that her condition became very bad when her mother died in 1995. She also said she was having problems with her husband, whom she described as very negative, particularly about her spending habits and ability to perform household chores such as cleaning and cooking.

At the time of discharge, Dr. Swaback found that she had a GAF of 60 and diagnosed her with a single episode of major depression, along with prolonged grief in reaction to the death of her mother. Dr. Swaback stated that she was no longer suicidal, nor psychotic, but that her "prognosis remains guarded. The patient does have significant stress factors going on in her life." (Tr. 116). Dr. Swaback prescribed Trazadone and Prozac.

On October 14, 1996, Torruella was treated by Dr. Wideman. She was having communication difficulties with her husband. Additionally, her mother-in-law had recently passed away and she was struggling with her loss. Dr. Wideman suggested outpatient psychiatric treatment. She diagnosed Torruella with Depression and Bipolar disorder and increased her Prozac.

On January 23, 1997, Dr. Wideman wrote that she was not crying as much but was still having trouble communicating with her spouse. She wrote, "overall - coping much better." She again prescribed Prozac as well as Trazadone. On March 24, 1997, Dr.

Wideman wrote that she was “spacing out” and having trouble focusing. She continued to have difficulties with her husband and counseling was not helping. She wanted to go to Iowa to see her father but her husband would not let her go. At her next appointment on June 23, 1997, Dr. Wideman wrote that she still had depression but that it was controlled with Prozac. She recommended that Torruella return in six months.

Throughout 1997 and 1998, Torruella fell several times. On July 21, 1997, Torruella fell and broke her toe. On March 30, 1998, Torruella fell, injuring her knee. In early May 1998, she fell again injuring the same knee and injuring her foot.

On December 8, 1997, Dr. Wideman wrote that Torruella was “generally feeling better” and her depression was improved. Torruella told Dr. Wideman that she felt a “more natural emotion.” Dr. Wideman encouraged Torruella to seek employment.

At an appointment for a physical on June 9, 1998, Dr. Wideman indicated that Torruella continued to suffer from depression, which was controlled through Prozac. Dr. Wideman wrote that she often mixed up her medications, which made their effect “suboptimal.” Torruella’s condition was aggravated by recent family events – her spouse had filed for divorce in February and also sought to terminate her custodial rights.

On September 1, 1998, Dr. Wideman indicated that her mental condition had worsened because she was going through a divorce. Dr. Wideman wrote that Torruella said, “[I am] back into behaviors that are harmful to me.” (Tr. 43). At that time, Torruella had begun seeing Licensed Clinical Social Worker Sally Fitts (Fitts’ treatment notes are detailed below). Dr. Wideman again diagnosed depression which was poorly controlled by Prozac. She also prescribed Effexor for her depression and anxiety.

Dr. Wideman spoke with Torruella’s social worker, Sally Fitts, on September 14, 1998. Fitts told Dr. Wideman that Torruella was experiencing increased stress at home, she was spending excessively, had “running thoughts,” and had difficulty focusing. She wrote that Torruella possibly suffers from Bipolar disorder, as well as depression and

impulsiveness.

Dr. Wideman saw Torruella on October 1, 1998. She wrote that Torruella was now seeing a psychiatrist, in addition to the social worker. Her psychiatrist, Dr. Douglas Lidge, M.D., had prescribed Depakote for bipolar swings. Dr. Wideman wrote that the Depakote has “helped her to calm down a bit, but she still has her ups and downs and is still battling the divorce and financial matters with her spouse.” (Tr.193). Torruella told Dr. Wideman that she had “lost all sense of direction.”

Torruella was treated approximately nineteen times by psychiatrist, Dr. Lidge. Dr. Lidge’s treatment notes indicated that Torruella struggled with depression, high financial spending, “anticipation anxiety,” worry about the future, problems in her marriage and interaction with her son. Throughout this time, Dr. Lidge wrote that she was having trouble finding a job, which caused her great anxiety. Dr. Lidge consistently prescribed Effexor and Depakote.

On October 23, 1998, Dr. Lidge wrote that Torruella was dealing with stress relating to moving out of her house. He noted some improvement in mood and that she “had one great day but still [illegible] of wanting to stay in bed.” Torruella was tearful about her divorce and financial situation and Dr. Lidge identified that she had abandonment issues. Dr. Lidge again prescribed Effexor and Depakote.

On November 17, 1998, Torruella saw Dr. Wideman who wrote that she was “going through a lot of stress with attorneys over her separation/divorce.” Dr. Wideman wrote that she was “feeling better,” although it is not clear from the treatment note whether she was feeling better in terms of her physical health, her mental/emotional health, or both. Torruella was taking Effexor, Depakote for her psychological problems, as well as Prempro for her menopause-related problems and Flexeril .

On November 23, 1998, Torruella returned to Dr. Lidge who wrote that she was still dealing with the stress of a deteriorating relationship with her husband and moving out

of her house. He wrote that she struggled with compulsive spending. He again prescribed Depakote and Effexor.

On January 18, 1999, Dr. Lidge wrote that she had increased depression, increased financial problems, and was sleeping more. He wrote that she “feels lost.” (Tr. 150).

On or around February 10, 1999, Dr. Lidge wrote that Torruella was improving. Her sleep was improved, she had increased her interest in spiritual matter and she was more optimistic. Her mood was improved and her affect pleasant.

As discussed above, Torruella was also treated by Licensed Clinical Social Worker Sally Fitts. Fitts treated Torruella from May 29, 1998 until March 22, 2000. In a treatment summary, she wrote that Torruella faced the following problems:

- “significant conflict with husband
- difficulty organizing time and responsibilities
- difficulty thinking clearly, racing thoughts
- little energy
- unable to get out of bed some days,
- reported sleeping some days for up to 16 hour stretches
- significant and sustained compulsive spending resulting in suspension of bank account and credit cards
- worried and anxious most days
- fear of abandonment and loneliness
- poor appetite
- obsessive thought processes
- unrealistic ideas about projects and interests.”

(Tr. 248).

Fitts wrote that Torruella had Bipolar disorder, Recurrent Major Depressive Episodes and Hypomanic episodes. The lowest GAF during treatment was 30 and the highest was 50. Fitts wrote the following summary of her two-year treatment of Torruella:

Ms. Tourella [sic] often missed her appointment and had to reschedule. When given intervention strategies to aid her in her functioning she generally had difficulty carry[ing] them out. Her emotional distress contributed to periods of time where she was unable to adequately manage her own general self-care. She would report not sustaining regular grooming, eating poorly and irregularly, and her home environment being in consistent chaos. An example would be when she reported she was having neck pain because she could not lie down to sleep due to her bed being covered in boxes of household items and her sofa being covered with stacks of papers, etc. Although Ms. Tourella [sic] was in desperate need of a job she was never able to organize and manage her life adequately to follow through with an application or interview process. Early on in treatment she was referred to a psychiatrist to receive medication support. She attempted to be consistent in her medication management. At the time of ending her treatment she was overwhelmed with the demands of deciding where she would live and was unable to keep her appointments.

(Tr. 249).

### **B. Plaintiff's Subjective Complaints**

On February 26, 2004, Torruella completed a Disability Report Adult form. She wrote that she stopped working in 1995 because of a miscarriage and then stayed home to raise her son. She stated that she worked as an operating room technician from 1968-1983. In that job, she walked one hour per day, stood for five hours, sat for a half an hour, stooped for one hour, handled, grabbed or grasped big objects for one hour, reached for one hour and wrote for one hour. The heaviest weight she lifted was twenty pounds and she frequently lifted ten pounds.

On September 19, 2004, Torruella completed a Disability Report Appeal. Torruella wrote that there had been major changes in her case since she filed for social security. She explained that one of her psychiatrists in Iowa sent her to a neurologist who found a grapefruit-sized tumor. The neurologist estimated that the tumor had been growing for

five to ten years, beginning sometime between 1994 and 1999.

On November 26, 2004, Torruella completed another Disability Report Appeal. She wrote, “I had tremors in 1998. I still have them to today but they are not as bad. I can’t walk very far now because of weakness. I need a cane to get around. I fell a lot when I lived in California. I didn’t know I had a brain tumor.” (Tr. 102).<sup>1</sup>

### **C. Third-Party Reports**

On May 4, 2004, Torruella’s ex-husband, Joseph Torruella, completed a Function Report Adult -Third Party form. Mr. Torruella wrote that he had know Ms. Torruella for about thirty years. They stopped living together in 1998 and were officially divorced in January 2004.

He wrote that up to 1998, Ms. Torruella managed the family’s household well. In terms of her ability to maintain self-grooming such as dressing, bathing, caring for her hair, etc., he wrote, “I think she had problems with all these activities before her brain surgery in 04. However before 1998 she was a very fastidious person.” (Tr. 84). Of her hobbies and interests, Mr. Torruella wrote that she did “great needle point, knitting, [and] raising ferns before 1998.” (Tr. 87).

Mr. Torruella wrote, “Till 1998 she was a competent loving wife and mother. After 1998 I thought she was crazy or just in love with another person. I understand her brain tumor could have been there 5-10 years. So what she went through might have been the brain tumor but who knows?” (Tr. 90).

Mr. Torruella also wrote a letter that was admitted as an exhibit at the hearing before the ALJ (Ex. 8E). He wrote:

In 1998 you seemed not to remember instructions. The most glaring example to me was when you forgot to pick up Adam after school and when I came home that night near 6 o’clock

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<sup>1</sup> Torruella also completed a Daily Activities Questionnaire on April 26, 2004, which is not summarized here because it does not pertain to the relevant time period.

and not found him home I went to the Waldorf School and picked him up. He had been waiting for 3-4 hours. At that point, I ordered him a cellular phone so that he could call me if similar circumstances arose.

As for when I asked you to do something such as preparing meals, household activities you voiced objections and generally were not available to do the activity. I was left mostly with putting Adam to bed, feeding his evening meals and explaining why you were not physically there.

. . .

During 1998 during most of the day you were curled up on the sofa in the living room with your face up against the pillows barely arousable, minimally communicative. Then you decided not to sleep with me and I thought you just wanted to be with your sweetheart Jim somebody.

On weekends you would sleep all of Saturday and Sunday and get some nourishment when I was asleep. During weekdays you were asleep in the living room when I left in the am and essentially in the same state when I came home at night.

. . .

Restrictions on daily living:

- Stopped going to Unity Services.
- Decreased your self care – i.e. makeup
- Stopped all marital activities
- Stopped most household connected activities
- Provided only marginal support to our son

. . .

She decided to buy a \$35,000 car with funds set aside for Adam without consulting anyone . . . .

Marcia decided to move out, had her own apartment where Adam went occasionally to sleep. The apartment was a shambles with cans of open food stuffs, rotting away, piles of newspaper and magazines and new furniture which was already showing the effects of excessive wear and filled cat litter boxes.

(Tr. 105-107).

#### **D. Residual Functional Capacity**

Dr. Deanna B. Boesen, M.E., a non-treating, non-examining agency psychiatrist, completed a Psychiatric Review Technique on July 30, 2004. Dr. Boesen indicated that Torruella's impairments were not severe from September 1995 to December 1997, and that there was insufficient evidence to determine the severity of impairments from January 1998 to December 1998. Dr. Boesen found that she had a 12.04 Affective Disorder and identified her impairment as depression. She concluded that Torruella had mild difficulties in social functioning from September 1995 until December 1997, but "evidence is insufficient to assess limitation and work-related functioning" during the 1998-1999 time period. (Tr. 240).

On March 19, 2005, Dr. Subramaniam Krishnamurthi, M.D., answered an interrogatory from the SSA. He indicated listed impairments of 11.04, 11.05, 11.02, 12.04, 5.08 and 11.06. He found that, while none of the listings singularly met a listed impairment, they equaled a listed impairment in combination.

On April 27, 2005, Dr. John Hickman, Ph.D., answered an interrogatory from the SSA. He determined that Torruella had Depression, Chronic pain, and bipolar disorder. He found that she had 12.02 impairment. He also found that her impairments, in combination, equaled the severity of a listed impairment. Dr. Hickman stated,

Claimant has dependent personality structure and stayed in an abusive marriage until she developed a severe depression which was intensified by the death of her mother. Unfortunately, she also developed a meningioma that was surgically removed but she has residual cognitive deficits. She was never able to handle a job prior to her increased depression, pain, and cognitive deficits much less now.

The synergistic effects of her combined disorders certainly equals the listing and if neuropsychological data was available she would probably meet criteria for 12.02 more clearly.

(Tr. 254-55).

### E. Hearing Testimony

ALJ W. Howard O'Bryan held Torruella's hearing on May 1, 2006. At the time of the hearing, Torruella was forty-eight years old. Vocational expert ("VE") Vanessa May testified.

Torruella's attorney requested that her onset date be modified from August 1, 1995 to March 1, 1998.

Torruella first discussed her physical and mental state in 1998. "There was a lot of sleeping, severe tremors that was excused on medication or blamed on medication. A lot of compulsive spending. I had taken money out of my son's education fund to purchase a new car without talking to anybody else first like my husband." (Tr. 370). She described a trip across country in which she spent around \$17,000 in one month.

She had difficulty recalling events of this time, but thought that it was around this time when she forgot to pick up her son from school. Also, she recalled that she did not recognize her husband one morning in 1998.

She also described severe mood swings: "It could be a beautiful day, everything would be going fine, and all of a sudden, I'd – one little trigger would have me crying and sobbing and totally losing track of what I was doing." (Tr. 372). Torruella said she slept a lot during this period, from about the fall of 1998 to winter 1999.

She also said that she was falling and tripping a lot. She sustained several injuries to her foot and knee from falling. "I was constantly tripping over nothing. It seemed as though my – I was losing control of my foot, my right foot. . . . I would fall on the sidewalk, fall on the steps, and they weren't big steps, they were like little four-inch risers. I could walk down a hardwood floor and trip." (Tr. 372).

It was not until several years later, in January of 2004, that a doctor in Iowa found that she had a brain tumor, which accounted for the tripping and problems with her foot.

The tumor was removed on January 25, 2004.

She said that she has trouble thinking and maintaining concentration. “I always start out on a conversation and lose my train of thought. I sometimes have to write notes to myself to remember to do things.” (Tr. 380). She said this problem began in 1992 or 1993.

The VE then asked the Torruella about her job as an operating room technician. She said the largest objects she had to lift were instrument pans which weighed about twenty to twenty-five pounds. At times, she would need to be on her feet for over eight hours. She estimated that seventy-five percent of her shift was on her feet. She stated that the last time she worked as an emergency room technician was in 1998. She was turned down for two jobs in the field after that. The VE said the physical demands of the job were light exertional.

The VE then discussed sedentary jobs that Torruella could perform. She could perform the jobs of a Holter monitor, cephalometric analyst, or cardiac monitor technician.

Torruella’s attorney then posed a hypothetical to the VE:

Let’s assume again that she could do sedentary work . . . but she would have difficulty organizing or – her responsibilities. And because of obsessive thoughts and anxiety, she would have frequent difficulty with her concentration and memory. Also because of depression, she would probably have several days a week that she wouldn’t be able to be to work maybe on time or maybe not show up at all. Also because of depression and irritability, she might have some difficulty getting along with people so maybe she should not work in the public and not in close proximity to other workers. With those limitations, would she be able to do . . . [a]ny other work?

(Tr. 388). The attorney then added moderate limitations in memory and concentration, which, at times, “would go the extreme of marked, let’s say, at least three times a week.” (Tr. 389).

The VE responded that those restrictions would preclude “any kind of skilled

work.” (Tr. 389). Further, if it was “persistent and she could not perform duties around co-workers or supervisors and had absences of two or more times a month, she could not be competitively employable.” (Tr. 389).

### **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 Baker v. Barnhart, 457 F.3d 882, 892 (8th Cir. 2006). “Substantial evidence is less than a preponderance, but is enough that a reasonable mind would find it adequate to support the Commissioner’s conclusion.” McKinney v. Apfel, 228 F.3d 860, 863 (8th Cir. 2000). The court must take into account evidence that fairly detracts from the ALJ’s findings, as well as evidence that supports it. Id. (citing Craig v. Apfel, 212 F.3d 433, 436 (8th Cir. 2000)). 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.

At the first step, the ALJ found that Torruella had not engaged in substantial gainful activity since March 1, 1998. (Tr. 20). At the second step, the ALJ determined that Torruella had the following severe impairments: depression, bipolar disorder, hypertension, and Parkinsonian tumor. (Tr. 21). At the third step, the ALJ determined that Torruella’s impairments met or equaled a listed impairment beginning Aug. 9, 2004 and therefore was disabled from that time. He found that the impairments did not meet or equal a listed impairment before the DLI, December 31, 1998. (Tr. 21). The ALJ determined that before that date, Torruella had an RFC of light work and “mild limitations

in activates [sic] of daily living, social functioning and concentration, persistence and pace.” (Tr. 20). At the fourth step, the ALJ concluded that Torruella could perform her past relevant work as an operating room technician before December 31, 1998 and therefore, was not disabled before her DLI. (Tr. 21).

### **C. Substantial Evidence in the Record**

Torruella argues that there is not substantial evidence to support the Commissioner’s decision that Torruella was not disabled prior to August 9, 2004. First, she argues that the ALJ ignored the opinion of an agency psychiatrist, Dr. Hickman. Second, she argues that there is no basis for the ALJ’s Residual Functional Capacity (“RFC”) assessment. Third, Torruella argues that the ALJ did not properly credit the opinion of her ex-husband, Joseph Torruella, who provided two third-party statements.

#### **1. Medical Experts**

Torruella first argues that the ALJ ignored the opinions of agency psychiatrist Dr. Hickman. The Commissioner concedes that the ALJ did not consider Dr. Hickman’s report, but argues that the ALJ need not specifically mention each medical source. Additionally, the Commissioner argues that the report was not for the appropriate period – it covered 1995 and 2004, not 1998.

The ALJ must consider all medical opinions in the record “together with the rest of the relevant evidence we receive.” 20 C.F.R. § 404.1527(b) (2007). “Regardless of its source, we will evaluate every medical opinion we receive.” *Id.* at § 404.1527(d). “[A]dministrative law judges must consider findings of State agency medical and psychological consultants or other program physicians or psychologists as opinion evidence . . . .” 20 C.F.R. 404.1527(f)(2)(I). While the opinions of agency consulting doctors such as Dr. Hickman “do not constitute ‘substantial evidence’ upon the record as a whole,” the ALJ has a duty to consider them. *Wagner v. Astrue*, 499 F.3d 842, 849 (8th Cir. Iowa 2007).

Dr. Hickman completed an interrogatory on April 27, 2005 (Tr. 253-55). The ALJ did not even mention Dr. Hickman's opinion. The totality of his comments about Torruella's medical records and opinions during 1998 are:

In June 1998, depression was described as controlled though suboptimal when the claimant manipulates her medications. In September 1998 she was going through a divorce and her depression was said to be poorly controlled and her mediations [sic] were changed. By the following months, she had show [sic] improvement. In February 1999, her depression was improved in [sic] Depakote. Her ex-husband completed a third-party ADL questionnaire but stated that up to 1998 the claimant managed the household well and was a competent, loving wife and mother. She created needlepoint and was able to balance a checkbook. Based on the treatment notes plus the ex-husband's description of functioning, the claimant only had mild difficulties in activities of daily living, social functioning and concentration, persistence and pace.

(Tr. 20). The court finds the Commissioner's argument that he need not consider Dr. Hickman's opinion unpersuasive. An ALJ has a duty to consider each medical opinion. See 20 C.F.R. § 404.1527(d). ("Regardless of its source, we will evaluate every medical opinion we receive.") While the ALJ will not likely give the same weight to a non-examining agency physician as he would a treating physician, the ALJ still needs to consider the opinion.

The Commissioner further argues that the interrogatory response did not cover the time period at issue in this appeal, March 1 through December 31, 1998. In the interrogatory, Dr. Hickman indicated that Torruella's impairments, in combination, equaled a listed impairment starting on August 1, 1995. He wrote that Torruella's impairments still equaled a listed impairment at the time he wrote the report on April 27, 2006. It seems clear from his report that Torruella's impairments equaled a listed impairment from August 1995 *through* April 2006. The court disagrees with the

Commissioner; Dr. Hickman's report was relevant to Torruella's condition in 1998. The ALJ should have considered Dr. Hickman's report for this time period.

## **2. Basis for RFC**

Torruella next argues that the ALJ's RFC is not based on substantial evidence for two reasons: (1) the RFC of light work is not based on medical evidence in the record or any identifiable source; and (2) the ALJ did not properly question the VE, therefore, he cannot rely on the VE's testimony. The Commissioner responds that "no doctor limited Plaintiff's physical abilities during 1998, so the ALJ was justified in providing no physical limitations but instead limiting Plaintiff to 'light' exertional type work." (Appellee Br. at 12).

### ***A. Medical Basis for the RFC***

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 [her] limitations." McKinney v. Apfel, 228 F.3d 860, 863 (8th Cir. 2000); 20 CFR § 404.1545 ("We will assess your residual functional capacity based on all the relevant evidence in your case record."). 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 totality of the ALJ's statements regarding Torruella's RFC were,

The claimant has past relevant work as an operation room technician which was performed at the light exertional level. Since the claimant's residual functional capacity on and prior

to December 31, 1998, has been determined to be for light exertion she was capable of performing her past work.

(Tr. 21).

The ALJ's opinion does not state, nor is it apparent from the record, what medical evidence he relies upon in making this RFC finding. The Commissioner argues that there is medical evidence in the record to support the RFC, specifically, the Psychiatric Review Technique performed by agency psychiatrist Dr. Deanna Boesen. "The state agency physician, Dr. Boeser [sic], found that Plaintiff's mental impairment was severe but not disabling during 1998." (Appellee Br. at 12). This is untrue. Dr. Boesen specifically stated that "evidence is insufficient to assess limitations and work-related functioning during this time period." (Tr. 246). Absent Dr. Boesen's assessment, or the opinion of any other medical source, there is not substantial medical evidence in the record on which to base the RFC of "light" work.

#### ***B. Vocational Expert Testimony***

The limitations presented to the VE did not include the RFC the ALJ assigned to Torruella – light exertional work. Rather, he questioned the VE about sedentary jobs and never asked her if Torruella could perform her past work. As he questioned her about these skills, the ALJ said, "[L]et's assume that I found she couldn't do anything other than, . . . skilled sedentary work." (Tr. 385). He asked the VE to "stick to just sedentary jobs where she could use these skills." (Tr. 385). Questioning the VE only about sedentary jobs, the ALJ did not gain any evidence from the VE upon which he could base his finding that Torruella could perform her past work.

With no medical source that supports the RFC finding and a lack of relevant evidence from the VE, the ALJ's RFC conclusion that Torruella could perform her past work is not supported by substantial evidence.

### **3. Consideration of Third-Party Statements**

Torruella last argues that the ALJ did not properly consider two third-party statements of her ex-husband, Joseph Torruella. Mr. Torruella completed a Third Party Function Report dated May 11, 2004 (Ex. 5E) and submitted a letter regarding his ex-wife, dated March 25, 2006 (Ex. 8E). Ms. Torruella argues that the ALJ misunderstood the report and did not even consider the letter, which is a detailed account of his wife's symptoms and functional limitations during 1998. The Commissioner responds that the ALJ sufficiently considered both the 2004 report and 2006 letter, as is indicated by his statement that he "considered all the evidence of record . . . including . . . statements in the record." (Tr. 20). The Commissioner characterizes the 2006 letter as cumulative of the medical record. "[I]t does not appear that this letter provides significant evidence that would outweigh the contemporaneous medical record on which the ALJ relied." (Appellee Br. at 14).

#### ***a. Mr. Torruella's Third Party Function Report***

The court agrees with Ms. Torruella that the ALJ misunderstood her ex-husband's third-party function report. The ALJ uses Mr. Torruella's statements about her ability to balance a checkbook and do needlepoint as evidence that she could function during the time period in question. But Mr. Torruella stated that she could do these activities *until 1998*, not during 1998. Throughout his statement, he indicates that 1998 was a turning point in her mental health and ability to function. He wrote:

- "Up to 1998 she managed our household well." (Tr. 84)
- "[B]efore 1998 she was a very fastidious person." (Tr 84)
- "[B]efore '98 she managed a checkbook." (Tr. 86)
- "Did great needle point, knitting, raising ferns before 1998." (Tr. 87)
- "Till 1998 she was a competent wife and mother. After 1998 I thought she was crazy or just in love with another person." (Tr. 90)

The ALJ mis-characterizes Mr. Torruella's statements about his then-wife's mental health and functioning. He seems to characterize the comments as indicating that *through* 1998, not *up to* 1998, she was a "competent, loving wife and mother," who was able to create needlepoint and balance a checkbook. It is clear that Mr. Torruella saw dramatic changes in his wife sometime before 1998 and that she had severe limitations during all, or at least part, of 1998. The ALJ's misreading and misunderstanding of Mr. Torruella's third-party statements undercuts the substantial evidence in the record as a whole.

***b. Mr. Torruella's Letter***

Mr. Torruella also submitted a lengthy letter regarding his ex-wife's condition in 1998. (See Part II.C). Ms. Torruella argues that the ALJ erred by not considering the letter. The Commissioner responds that the letter was duplicative of Mr. Torruella's third-party report and other evidence in the record.

An ALJ must consider the statements of family members, which the social security regulations refer to as "other source" opinions. See Smith v. Heckler, 735 F.2d 312, 317 (8th Cir. 1984) ("We have frequently criticized the failure of the Secretary to consider subjective testimony of the family and others."); 2006 SSR LEXIS 5 (SSR 2006). The regulations explain how "other source" opinions should be used:

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.

2006 SSR LEXIS 5 (SSR 2006).

The Eighth Circuit Court of Appeals recently clarified how a district court should review an ALJ's failure to assess such statements of spouses and family members. Willcockson v. Astrue, No. 07-357, 2008 U.S. App. LEXIS 18505 (8th Cir. Aug. 28, 2008). If the ALJ does not even mention the evidence, the case should be remanded for

consideration of the third-party claims. Id. at \*5-6. However, an ALJ's failure to explain why he or she rejected a third-party's statement does not necessarily require remand, so long as the opinion makes clear that the third party's statements were considered. Id.; see also Turley v. Sullivan, 939 F.2d 524, 528 (8th Cir. 1991) (citing Smith v. Heckler, 735 F.2d 312 (8th Cir. 1984); Basinger v. Heckler, 725 F.2d 1166 (8th Cir. 1984)) ("The ALJ must . . . at the least, [provide] proof that he or she gave such testimony adequate consideration."). But where "the decision does not say that the statements were considered at all," the court must remand to the ALJ for a further consideration of the third-party opinion. Wilcockson, 2008 U.S. App. LEXIS 18505, at \*6.

There is no indication that the ALJ considered Mr. Torruella's 2006 letter. He did not mention the letter, nor did he even cite it as an exhibit. The Commissioner argues that the ALJ did not need to reference the letter because it was cumulative of the Third-Party Function Report. While there was some overlapping information, the letter was much longer and more detailed. It discussed her ability to carry-out parenting duties, memory and concentration problems, overspending habits, lack of communication, excessive sleeping, poor self-grooming, retreat from their church, retreat from their marital activities, and poor maintenance of her apartment. In sum, Mr. Torruella's letter is a valuable insight into Ms. Torruella's life and ability to carry out activities of daily living in 1998. The ALJ erred in not considering the letter.

#### **D. Reversal or Remand**

The scope of a district court's review of the Commissioner's final decision is set forth in 42 U.S.C. § 405(g) which provides, in part, "The court shall have the power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Secretary, with or without remanding the cause for a rehearing." 42 U.S.C. § 405(g). The Eight Circuit Court of Appeals has stated, "[w]here the total record is overwhelmingly in support of a finding of disability and the claimant has demonstrated [her] disability by medical evidence on the record as a whole, we find no

need to remand.” Gavin, 811 F.2d 1195, 1201 (8th Cir. 1987); see also Beeler v. Bowen, 833 F.2d 124, 127 (8th Cir. 1987) (although there was no shift in the burden to the Secretary, reversal or denial of benefits was proper where “the total record overwhelmingly supports a finding of disability”); Stephens v. Secretary of Health, Educ. & Welfare, 603 F.2d 36, 42 (8th Cir. 1979) (reversal of denial of benefits is justified where no substantial evidence exists to support a finding that the claimant is not disabled). If a remand for “further hearings would merely delay receipt of benefits, an order granting benefits is appropriate.” Parson v. Heckler, 739 F.2d 1334, 1341 (8th Cir. 1984).

Considering the totality of the medical evidence, the record demonstrates that Ms. Torruella had a combination of impairments that equaled a listed impairment before her DLI, December 31, 1998. The medical record includes the opinion of Dr. Hickman, an agency psychiatrist, who opined that she was disabled all the way back to 1995, yet the ALJ ignored this opinion, even though given by his own agency’s doctor. Further, the court finds that the treatment notes of Torruella’s general practitioner, Dr. Wideman, psychiatrist Dr. Lidge, and social worker Sally Fitts all consistently point to a worsening psychological condition in 1998 due to her divorce and home situation. It is also telling that prior to the fall of 1998, Torruella only sought medical treatment from Dr. Wideman, a general physician. However, starting around September or October of 1998, she began seeing both a social worker and a psychiatrist because of her psychological issues and difficulty dealing with her divorce. Last, the court notes that these records are consistent with the very thorough third-party reports of Mr. Torruella. The second report, which was significantly longer and more detailed, was not even considered by the ALJ. His descriptions of Ms. Torruella’s daily activities, or lack thereof, are consistent with the treatment record and show that Ms. Torruella was not psychologically capable of maintaining regular, sustained competitive employment at that time. In sum, the medical record demonstrates disability before Torruella’s DLI. Further hearings would merely delay receipt of benefits. Reversal for an award of benefits is proper in this case.

Upon the foregoing,

**IT IS ORDERED** that the decision of the Commissioner of Social Security is hereby reversed. The Clerk of Court shall enter judgment accordingly.

**DATED** this 11th day of September, 2008.

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