

TO BE PUBLISHED  
IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF IOWA  
CENTRAL DIVISION

KIMBERLY K. KINSETH,

Plaintiff,

vs.

CAROLYN W. COLVIN,  
Commissioner of Social Security,

Defendant.

No. C12-3033-MWB

**REPORT AND RECOMMENDATION**

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***Introduction***

Plaintiff Kimberly Kinseth<sup>1</sup> seeks judicial review of a final decision of the Commissioner of Social Security (the “Commissioner”) denying her application for disability insurance benefits (“DIB”) pursuant to Title II of the Social Security Act, 42 U.S.C. § 405(g). Kinseth contends the administrative record (“AR”) does not contain substantial evidence to support the Commissioner’s decision that she is not disabled. For the reasons that follow, the undersigned recommends that the Commissioner’s decision be affirmed.

***Background***

Kinseth was born in 1961, completed high school, and completed courses in cosmetology and nursing. AR 35, 131. She has past relevant work as a nurse’s aide and an assembler in a factory. AR 312. Kinseth protectively filed for DIB on May 29, 2009, alleging disability beginning on October 10, 2008, due to bipolar disorder, fibromyalgia, degenerative disc disease, arthritis, bulging disk, asthma and depression.

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<sup>1</sup> The administrative record refers to the claimant as Kimberly Kuester. Her last name is now Kinseth. See Doc. No. 7 at 1, n.2.

AR 192-205. Her claims were denied initially and on reconsideration. AR 61-73. Kinseth requested a hearing before an Administrative Law Judge (“ALJ”). AR 74. On April 14, 2011, ALJ John E. Sandbothe held a hearing during which Kinseth and a vocational expert (“VE”) testified. AR 32-55.

On April 25, 2011, the ALJ issued a decision finding Kinseth not disabled since October 10, 2008. AR 9-31. Kinseth sought review of this decision by the Appeals Council, which denied review on April 5, 2012. AR 1-3. The ALJ’s decision thus became the final decision of the Commissioner. 20 C.F.R. §§ 404.981.

On May 18, 2012, Kinseth filed a complaint in this court seeking review of the ALJ’s decision. This matter was referred to the undersigned United States Magistrate Judge pursuant to 28 U.S.C. § 636(b)(1)(B) for the filing of a report and recommended disposition of the case. The parties have briefed the issues, and the matter is now fully submitted.

### *Summary of Evidence*

I have reviewed the entire administrative record and find the following evidence relevant to Kinseth’s claim:

#### **A. *Medical Evidence of Physical Impairment***

Kinseth began seeing Mark Johnson, M.D., at Mercy Internal Medicine Clinic in 2007 for her fibromyalgia and chronic back pain. AR 393-95. Dr. Johnson prescribed Lortab three times per day under a pain contract.<sup>2</sup> *Id.* In November 2007, Dr. Johnson

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<sup>2</sup> Despite this pain contract, it appears from the record that Kinseth was receiving Lortab prescriptions from two different providers from 2007 through 2009. Kinseth was initially prescribed Lortab by David Ruen, M.D., in April 2005 with instructions to use it sparingly. AR 322. Dr. Ruen noted that she was not to use Soma in the future. *Id.* By October 2007, Kinseth had transferred her care to Glee Christ, ARNP, at Belmont Medical Center and Dr. Johnson at Mercy, both of whom prescribed Lortab. AR 367, 395. Ms. Christ originally prescribed Lortab and Soma three times per day, but decreased the prescriptions to two times per day in October 2007. *Id.* In February 2008, she noted Kinseth was pleading with her to

noted her back pain was “quite well controlled.” AR 393. Dr. Johnson also prescribed medication for Kinseth’s mood disorder with sleep disorder. AR 391. He suggested she transfer to a primary care provider in 2008, but Kinseth continued seeing Dr. Johnson for several issues and he continued prescribing her medication. AR 387, 388, 390.

In May 2009, Dr. Johnson wrote that Kinseth had fairly typical symptoms of fibromyalgia and had carried this diagnosis for much of her adult life. AR 383. He noted that her symptoms waxed and waned and she would have weeks where she was comfortable and weeks when she was debilitated. *Id.* He wrote, “Even simple exercise can exacerbate her pain, especially upper shoulder neck pain and sometimes lower extremity limb and girdle discomfort.” *Id.*

Kinseth began seeing Jennifer Gibson, M.D., for back pain in July 2009. AR 446. Kinseth noted that her pain worsened with increased activity. *Id.* She explained if she pushed herself when her pain felt under control, it would flare up and she would have to spend the next two to three days in bed. *Id.* Dr. Gibson spoke with Kinseth about time management and pacing, suggesting this could help control some of her pain symptoms. AR 447. She asked that Kinseth get a urine drug screen before her next appointment so they could transfer her medication management from Dr. Johnson and set up a pain contract. AR 448.

Kinseth did not come in for a drug screen before her next appointment, stating she had been busy with her grandchildren. AR 445. She provided a urine sample at the appointment and was given a three-week supply of her prescriptions to last until her next scheduled appointment. *Id.* The drug screen came back positive for

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increase the dosage but she was uncomfortable with Kinseth’s excessive use of Lortab and Soma. AR 364. She noted that an extensive workup had been done with negative results and that a MRI showed very mild degenerative disk disease at L5-S1 but was otherwise unremarkable. *Id.* Kinseth continued receiving Lortab and Soma prescriptions from Ms. Christ until at least February 2009 and Lortab from Dr. Johnson until July 2009 when her medication management was transferred to another provider. AR 353, 448.

amphetamine. AR 444. Kinseth said she had borrowed Adderall from a friend. *Id.* She apologized and said it would never happen again. Dr. Gibson discussed the pain contract for her Lortab prescription. *Id.* She wrote that a drug screen would be performed at every visit for the next six months. *Id.*

In October 2009, a MRI of Kinseth's spine was taken. AR 476-81. The results were summarized in a letter from David Ruen, M.D., on October 6, 2009. AR 487.

The results of your recent x-ray showed essentially no evidence of arthritis, degenerative disease or other problems. There were a couple of benign pelvic calcifications but it was otherwise unremarkable. Your neck x-ray showed minimal arthritis at C4-5 and an unfused accessory ossification center at C2-3. Your MRI scans of these areas showed a broad based disk bulge left greater than right at the C4-5 level. You had normal cord signal throughout the neck. There was no abnormal enhancement. Your MRI scan of the lumbar spine showed mild interspaced narrowing without evidence of significant arthritis. There was no spinal canal narrowing. There was minimal bulging. There was no evidence of any kind of tears and certainly no herniated disk or even bulging disks. Congratulations on these very excellent results. I look forward to our next visit.

On November 11, 2009, Dr. Gibson discussed Kinseth's functional abilities with her and made the following record:

1. She finds that pain interferes with her ability to lift weights. She can only lift five to ten pounds of weight occasionally because this does bother her neck and back.
2. The patient is not able to sit for more than 20 minutes or stand for more than 20 minutes without needing to take a break or change position. She can only walk one block before she has to sit down.
3. She has discomfort with stooping, kneeling, climbing, and crawling, and I would suggest that she avoid these activities completely.

4. She is capable of sight, hearing, speech. Travel would be limited by the restrictions on sitting, standing, and walking, handling of small objects with her hands. She does have swelling with prolonged use of both her hands and her feet.
5. We also talked about the fact that she has trouble working for prolonged periods. She did do house chores a few weeks ago. She worked about six hours straight and took 10-minute breaks as if she was at work, and by the end of the evening had to go [to] the emergency room with pain and swelling.

She does have flare-ups of her fibromyalgia. Some days are better than others. On the flare-up days, she may have pain that is severe enough that she needs to lie down for most of the day.

We have talked about pacing. I have suggested that she not work for more than 20 or 30 minutes without taking a more extensive break, possibly a 20 to 30-minute break, and she has tried to follow that in her daily life.

AR 527-28. On November 20, 2009, Dr. Gibson completed a questionnaire at the request of Kinseth's attorney. AR 558-59. She wrote that Kinseth could not stand or sit for more than 20 minutes at a time without experiencing pain and she could not kneel, climb, crawl or stoop. *Id.* She suggested that Kinseth's impairments would affect her attendance at work and her ability to perform under pressure. She also noted that Kinseth's concentration was impaired. *Id.* She stated a flare up of fibromyalgia pain could cause Kinseth to miss work. She also reported Kinseth's chronic pain was unlikely to improve and impaired Kinseth's daily functioning. *Id.*

On January 5, 2010, Dr. Gibson expressed concern that Kinseth may have been receiving her Vyvanse prescription from a second provider. AR 596. She also noted that Kinseth had requested early refills of her prescriptions on two occasions. *Id.* On one occasion, Kinseth requested an early refill stating she had lost her luggage while traveling. *Id.* Dr. Gibson denied this request. *Id.* On January 6, 2010, Kinseth

reported that Dr. Johnson would no longer prescribe her Vyvanse because he believed she was seeking the prescription from multiple providers. Dr. Gibson also refused to prescribe Vyvanse, noting that Robert Stern, D.O., thought she should not take that medication. AR 595. Dr. Gibson stated that any prescription for Vyvanse would have to come from a psychiatrist. *Id.*

***B. Medical Evidence of Mental Impairment***

On February 1, 2008, Dr. Johnson noted that Kinseth reported significant problems with sleep disorder and mood disorder. AR 424. She improved while taking Depakote but stopped using it. Dr. Johnson advised her to continue taking it and increased her prescription. *Id.* Later that month, Kinseth sought help for exacerbation of her depression from Glee Christ, ARNP, at Belmont Medical Center. AR 364. Her Effexor prescription was increased. *Id.* On May 9, 2008, Ms. Christ noted that Kinseth's moods were stabilized and she had been sleeping well. AR 363.

On May 12, 2009, Kinseth reported to Dr. Johnson that she thought she had bipolar disease. AR 387. Based on her description of symptoms, he noted, "I do think she is correct" and he prescribed Lamictal. AR 383-87.

In July 2009, Kinseth saw R.M. Ramos, M.D., at Mental Health Center of North Iowa for evaluation of attention deficit disorder. AR 440. She explained that she did not have symptoms of hyperactivity, but had difficulties concentrating on one task and finishing things she would start. Dr. Ramos indicated he wanted to perform more tests before diagnosing her and prescribing medication. AR 441.

On August 13, 2009, Brent Seaton, Ph.D., performed a neuropsychological evaluation for diagnostic clarification and treatment planning regarding Kinseth's bipolar disorder and possible attention deficit/hyperactivity disorder ("ADHD"). AR 400. Dr. Seaton concluded Kinseth's full scale IQ was 77, which is within the borderline range of general intellectual functioning. AR 405. Dr. Seaton noted that she was likely prone to difficulties interacting with people, especially those in positions

of authority. AR 407. He diagnosed her with bipolar II disorder and gave her a provisional diagnosis of ADHD, stating that he needed more objective evidence. *Id.* He suggested that medication and individual therapy would be helpful. AR 408.

Dr. Johnson wrote a letter on behalf of Kinseth on October 8, 2009, stating:

She has been unable to work because of her underlying bipolar type II disorder. She also has chronic pain syndrome which is not under my direct care, the patient seeing Dr. Jennifer Gibson for this reason, but this has also been debilitating.

She requires multiple drug therapy for mood stabilization and with the contingent comorbidities of psychiatric illness and drug side effects, she is unable to perform any type of work at this time.

This letter is to document her chronic pain syndrome as well as her history of bipolar depression and I am supporting her filing for disability because of her long-standing debility.

AR 504.

Kinseth began seeing Jon Ahrendsen, M.D., in February 2010 for ADHD. AR 626-27. Dr. Ahrendsen suggested she try methyl B-12 injections for ADHD and fibromyalgia in addition to a trial of stimulant medication. AR 628. Kinseth later called saying she would like to try Adderall, noting she had taken it before and did not have any side effects. AR 628-29. Dr. Ahrendsen prescribed Adderall. *Id.* Kinseth reported the Adderall made her feel better, although it would wear off after approximately four hours. AR 625. Dr. Ahrendsen conducted an attention assessment test and increased the dosage. *Id.* On August 2, 2010, Kinseth called in to get an early refill on her Adderall stating she had been in a car accident and lost her medication. AR 622. Dr. Ahrendsen found an on-call provider who was willing to prescribe enough medication to last until her next refill date if Kinseth brought in a police report. *Id.* Dr. Ahrendsen's office tried calling Kinseth multiple times and left multiple voicemails for her on August 2, 3, 4, and 5, but she never called back and did not get

an early refill. *Id.* Medication management of Kinseth's Lortab prescription was transferred to Dr. Ahrendsen from Dr. Gibson in September 2010. AR 633-34.

Dr. Ahrendsen wrote a letter on March 28, 2011, to confirm Kinseth's diagnosis of ADHD. AR 661. He wrote that he had been treating her for ADHD for several years and she had improved with proper medication management. *Id.* He indicated that she still suffers difficulty with focusing and maintaining attention for a long period of time. He noted that Kinseth suffers from bipolar features, chronic depression and chronic back pain. He stated her back pain results in physical limitations of lifting, bending, walking and carrying. *Id.* He concluded, "I believe Kimberly has a sufficient number of medical problems including bipolar issues, depression issues, ADHD issues, chronic back pain issues that her application for disability is a reasonable one." *Id.*

### ***C. State Agency Consultants***

Scott Shafer, Ph.D., performed a mental residual functional capacity ("RFC") assessment and psychiatric review technique on September 22, 2009. AR 457-74. He found that she had moderate limitations in her ability to understand, remember, and carry out detailed instructions and maintain attention and concentration for extended periods. AR 457-58. In all other areas she was not significantly limited. *Id.* Dr. Shafer summarized the medical evidence and Kinseth's daily activities. AR 459. He found her severe mental impairment did not meet or equal a listing. He noted that she was able to sustain employment in the past and stopped working due to her medications. *Id.* Her Global Assessment of Functioning ("GAF")<sup>3</sup> scores of 50 to 55 indicated a moderate level of impairment and her daily activities showed that she can handle daily responsibilities and negotiate the community independently. *Id.* He found

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<sup>3</sup> A GAF score represents a clinician's judgment of an individual's overall ability to function in social, school, or occupational settings, not including impairments due to physical or environmental limitations. See American Psychiatric Ass'n, *Diagnostic & Statistical Manual of Mental Disorders* 34 (4th ed.) (DSM-IV). A GAF score of 51-60 indicates moderate symptoms or moderate difficulty in social, occupational, or school functioning.

that her attention, concentration, and pace are adequate for routine tasks not requiring sustained attention and she can interact appropriately with the public, coworkers, and supervisors. *Id.* Her judgment was also adequate to adjust to changes in the workplace. In his psychiatric review technique, he found moderate difficulties in maintaining concentration, persistence, or pace, mild difficulties with activities of daily living and maintaining social functioning, and no episodes of decompensation. AR 471.

Melodee Woodard, M.D., performed a physical RFC assessment on October 7, 2009. AR 488-95. She found that Kinseth could occasionally lift and/or carry 20 pounds, frequently lift and/or carry 10 pounds, could stand and/or walk about 6 hours in an 8-hour workday and could sit for the same. AR 489. She could also be expected to occasionally climb, balance, stoop, kneel, crouch or crawl. She was to avoid any overhead reaching and concentrated exposure to extreme cold and hazards such as machinery or heights. AR 491-92. Dr. Woodard noted that in December 2008, July 2009, and August 2009, Kinseth reported Lortab was “quite helpful” in relieving her symptoms. AR 495. She also noted attempts by Kinseth’s physicians to wean her off narcotics. *Id.* As for her fibromyalgia, Dr. Woodard noted Kinseth had not sought treatment for diffuse pain before July 2009 and it was unclear who initially gave her this diagnosis. *Id.* Kinseth reported the TENS unit helped and Dr. Gibson recommended time management and pacing in addition to treatment to relieve her symptoms. *Id.* Finally, Dr. Woodard noted that testing revealed that Kinseth had a tendency to potentially exaggerate the nature of her complaints and that she attributed the loss of her 26 jobs to non-physical impairments. *Id.*

Sandra Davis, Ph.D., performed a mental RFC assessment and psychiatric review technique on December 21, 2009. AR 560-77. Dr. Davis noted that Kinseth’s claim was being reconsidered due to new allegations that Kinseth was more forgetful and less able to concentrate. AR 576. In addition to the moderate limitations previously identified by Dr. Shafer, she also found moderate limitations in her ability

to: perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances; work in coordination with or proximity to others without being distracted by them; complete a normal workday and workweek without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods; 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, and respond appropriately to changes in the work setting. AR 574-75. In all other areas she was not significantly limited. *Id.*

In summary she wrote:

[T]he claimant has some problems with understanding and carrying out more detailed tasks. She would have fluctuating attention and concentration. Pace will be slower than that of others. She may have difficulty relating to authority, and be distracting to others. She is doing less in terms of her household activities and ADL's at present. She has pursued stimulants for her possible ADHD, but has done some of that without medical supervision. [Treating source] opinion is from a physician she no longer sees and whose specialty is not mental health; as such, more weight is given to those mental health practitioners she has seen.

AR 577. Dr. Davis also noted that Kinseth's credibility could be challenged based on her seeking stimulants from two sources and borrowing medication from a friend, as well as her husband's reports which indicated more positive daily functioning than Kinseth herself did. *Id.*

#### ***D. Kinseth's Testimony***

At the hearing, Kinseth testified she completed twelfth grade and had taken additional classes in cosmetology and nursing. AR 35. She said she had been in special education throughout high school for language and math. *Id.* She testified that she has problems with memory, concentration and staying on task. AR 36. She

thought she could stay on task for 15 minutes at a time and had greater difficulty concentrating when other people were around her. AR 37. Kinseth testified that her difficulties with lifting, sitting and staying on task in addition to her mental impairments prevent her from working. AR 38.

As for mental impairments, Kinseth testified that her bipolar disorder causes irregular sleeping patterns. She sometimes slept four days in a row and other times she could only sleep for a couple hours. *Id.* She said her ADHD made her argumentative and she had trouble getting along with people. AR 39. She reported that she often challenged her supervisors in past jobs and lost jobs for that reason. AR 40-41. Kinseth said she would normally stay at a job for no more than three months. AR 41. She reported missing 28 days out of two months at her last job as a nurse's aide. *Id.* She said she also had a tendency to become obsessed with simple tasks so that she would spend the majority of the day working on one thing. AR 39-40.

With regard to physical impairments, Kinseth stated that she needed to switch positions at least every 40 minutes. AR 42-43. She described difficulties with lifting, standing and sitting related to her fibromyalgia pain. *Id.* She said the more she pushes herself, the more pain she experiences, and she is taking the maximum dosage that is recommended of her medication. *Id.* In describing her fibromyalgia pain, Kinseth said it radiates out from a spot in her shoulder. AR 43. As for back pain, Kinseth said her doctors have told her to switch positions when she experiences soreness. *Id.* Her medication does not stop the pain. She thought she could stand for 40 minutes and sit for 45 minutes before needing to switch positions. AR 43-44. She stated she is able to walk two to three blocks. AR 44. She also described difficulties with bending, kneeling and lifting. AR 44-45.

On a typical day, Kinseth stated that she would watch television, read and get on the computer. She would try to go to doctor's appointments when she had them, but would often re-schedule them because she did not want to leave her house. AR 45-46. She testified she did not do housework, yard work, or take care of her pets, and that

other people would help her out with these things. *Id.* She explained that if she tried to do things such as vacuuming, she would be sore the next day. AR 46. Kinseth said she would sometimes go visit places with the help of a friend to share her story about her prior drug use. AR 46-47. She has been clean for 10 years. AR 47. Someone would usually go grocery shopping with her or she would give a list to someone else. She said that if she went by herself, she would spend too much time in the store and buy more than she intended. *Id.* She testified that she sometimes has problems taking care of herself and her daughter would have to remind her to take a shower. AR 48. She stated that any changes in routine would cause her stress, which would exacerbate her symptoms. AR 49. Kinseth thought she would be unable to return to any of her past jobs because she would argue with people. AR 51.

***E. Vocational Expert's Testimony***

The ALJ summarized Kinseth's vocational and medical background then gave the VE the following hypothetical:

She could lift 20 pounds occasionally, 10 pounds frequently; she could only occasionally balance, stoop, crouch, kneel, crawl, climb; simple routine, and repetitive work; no contact with the public; regular pace.

AR 52. The ALJ stated he did not believe any of Kinseth's past work would be available under this hypothetical, but asked the VE if there were other jobs she could perform. *Id.* The VE answered that the jobs of routine clerk, laundry folder and housekeeper were available within these limitations and existed in significant numbers within Iowa and the national economy. AR 52-53.

The second hypothetical provided by the ALJ contained the same limitations as before with additional limitations of standing for a total of two hours during the workday, two or more absences per month and slow-paced work for up to one-third of

the day. AR 53. The VE responded that a person with these limitations and Kinseth's vocational and medical background would not be competitively employable. *Id.*

Kinseth's attorney also asked the VE hypotheticals. He first asked if any of the jobs from the first hypothetical would be affected if the individual needed to take a 20-minute break after every 20 to 30 minutes of work. *Id.* This was based on a treatment note from Dr. Gibson. *Id.* The VE answered that an individual who required two or more unscheduled breaks per day would not be competitively employable on a full-time basis. AR 53-54. Kinseth's attorney also asked if any of the jobs from the first hypothetical would be affected if an individual could only stay on task 10 to 15 minutes at a time without completing her tasks. AR 54. The VE responded 'yes.' *Id.* Finally, the attorney referenced Kinseth's testimony about her confrontational behavior towards supervisors. *Id.* The VE stated that not many employers would tolerate frequent conflict in the workplace on a regular basis. AR 54-55.

### *Summary of ALJ's Decision*

The ALJ made the following findings:

- (1) The claimant meets the insured status requirements of the Social Security Act through June 30, 2013.
- (2) The claimant has not engaged in substantial gainful activity since October 10, 2008, the alleged onset date (20 CFR 404.1571 *et seq.*).
- (3) The claimant has the following severe impairments: subaverage intellectual functioning; fibromyalgia; bipolar disorder; and ADHD (20 CFR 404.1520(c)).
- (4) The claimant does not have an impairment or combination of impairments that meets or medically equals one of the listed impairments in 20 CFR part 404, Subpart P, Appendix 1 (20 CFR 404.1520(d), 404.1525 and 404.1526).
- (5) After careful consideration of the entire record, the undersigned finds that the claimant has the residual

functional capacity to perform light work as defined in 20 CFR 404.1567(b) such that she can lift and carry twenty pounds occasionally, ten pounds frequently; occasionally balance, stoop, kneel, crouch, crawl, and climb; she is limited to simple routine repetitive work; she can have no contact with the public; and she can work at no more than a regular pace.

- (6) The claimant is unable to perform any past relevant work (20 CFR 404.1565).
- (7) The claimant was born on April 1, 1961 and was 47 years old, which is defined as a younger individual age 18-49, on the alleged disability onset date. The claimant subsequently changed age category to closely approaching advanced age (20 CFR 404.1563).
- (8) The claimant has at least a high school education and is able to communicate in English (20 CFR 404.1564).
- (9) Transferability of job skills is not material to the determination of disability because using the Medical-Vocational Rules as a framework supports a finding that the claimant is “not disabled,” whether or not the claimant has transferable job skills (See SSR 82-41 and 20 CFR 404, Subpart P, Appendix 2).
- (10) Considering the claimant’s age, education, work experience, and residual functional capacity, there are jobs that exist in significant numbers in the national economy that the claimant can perform (20 CFR 404.1569 and 404.1569(a)).
- (11) The claimant has not been under a disability, as defined in the Social Security Act, from October 10, 2008, through the date of this decision (20 CFR 404.1520(g)).

AR 14-25.

After finding that Kinseth had medically determinable physical and mental impairments, the ALJ considered how those impairments affected Kinseth's functioning. First, he examined the medical evidence. He reviewed Dr. Seaton's neuropsychological evaluation, which confirmed the diagnosis of many of Kinseth's impairments. AR 16. He also considered the state agency consultants' assessments. The ALJ noted they were considered non-treating specialists and gave their opinions significant weight as they were consistent with the record as a whole. AR 16-20. He summarized Dr. Ruen's letter to Kinseth congratulating her on her excellent results from her MRI which essentially showed no evidence of arthritis, degenerative disease or other problems. AR 17.

The ALJ also considered the opinions of Kinseth's treating physicians. He considered the letter Dr. Johnson wrote on Kinseth's behalf, noting that Dr. Johnson was Kinseth's treating physician for her headaches and pain management. The ALJ found this opinion to be "quite conclusory" with "very little explanation of the evidence relied on in forming that opinion." AR 19. The ALJ also noted that it expressed an opinion on an impairment outside Dr. Johnson's area of expertise and failed to indicate what clinical findings and objective medical records supported it. Therefore, the ALJ gave it no weight. *Id.*

The ALJ considered the questionnaire Dr. Gibson completed at the request of Kinseth's attorney. *Id.* Dr. Gibson stated she had treated Kinseth since July 2009 for fibromyalgia, osteoarthritis and chronic headaches. The ALJ found Dr. Gibson's assessment of degenerative disease based on direct examination and the MRI inconsistent with Dr. Ruen's assessment of the MRI. *Id.* Dr. Gibson had opined that Kinseth could stand or sit for no longer than 20 minutes and never kneel, climb, crawl, or stoop. She also found that Kinseth's regular attendance and performance would impair her concentration and overexertion would likely cause Kinseth's fibromyalgia to flare up causing her to miss work. Dr. Gibson stated Kinseth's chronic pain was unlikely to improve and would impair her daily function. *Id.* The ALJ gave Dr.

Gibson's opinions "very little weight" stating they were based on a short treating history and were inconsistent with the objective medical evidence in the record. *Id.*

Finally, the ALJ considered Dr. Ahrendsen's opinion. Dr. Ahrendsen stated he had treated Kinseth for ADHD for several years. AR 21. He reported her difficulties with focusing and maintaining attention for long periods of time. The ALJ noted that Dr. Ahrendsen had only been treating Kinseth since February 2010, and Kinseth had only seen him a few times. *Id.* The ALJ also noted that Kinseth's medication management had been transferred to Dr. Ahrendsen from Dr. Johnson and Dr. Gibson. The ALJ gave Dr. Ahrendsen's opinion little weight as it was inconsistent with the medical evidence, including his own treatment notes which indicated Kinseth was doing better with no reported side effects from the Adderall she started in February 2010. *Id.*

In determining Kinseth's RFC, the ALJ also considered Kinseth's subjective allegations concerning her functional limitations. Kinseth's allegations of limited daily activities were considered outweighed by other factors. AR 22. The ALJ noted that Kinseth had provided inconsistent information regarding her daily activities. She stated in February 2010 she was not able to go shopping or walk several blocks, but at the hearing she stated she had gone shopping for two hours and had recently gone for a walk. AR 23. She also testified she was able to work on the computer for up to eight hours, which the ALJ found inconsistent with her statements that she could not sit for longer than 20 minutes without needing to change position. *Id.* The ALJ also did not give much weight to her husband's allegations because he could not be considered a disinterested third party and his allegations were inconsistent with the preponderance of the opinions and observations by medical doctors. *Id.* The ALJ also did not think the husband's allegations established that Kinseth was disabled. Finally, the ALJ found that Kinseth's attempts at getting early refills of her medications and breaking her pain contract diminished her credibility. *Id.*

Overall, the ALJ found the RFC was supported by the objective medical evidence. He noted the treatment notes did not support Kinseth's subjective allegations

and the state agency medical consultants' opinions were internally consistent and consistent with the record as a whole. Kinseth's subjective allegations were discredited by inconsistencies in her reported daily activities and the medical records. The ALJ found that she could perform other work available in the national economy with the limitations described in the RFC. AR 23-25.

### ***Disability Determinations and the Burden of Proof***

A disability is defined as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than twelve months. 42 U.S.C. §§ 423(d)(1)(A), 1382c(a)(3)(A); 20 C.F.R. §§ 404.1505, 416.905. A claimant has a disability when the claimant is “not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists . . . in significant numbers either in the region where such individual lives or in several regions of the country.” 42 U.S.C. §§ 423(d)(2)(A), 1382c(a)(3)(B).

To determine whether a claimant has a disability within the meaning of the Social Security Act, the Commissioner follows a five-step sequential evaluation process outlined in the regulations. 20 C.F.R. §§ 404.1520, 416.920; *see Kirby v. Astrue*, 500 F.3d 705, 707 (8th Cir. 2007). First, the Commissioner will consider a claimant's work activity. If the claimant is engaged in substantial gainful activity, then the claimant is not disabled. 20 C.F.R. §§ 404.1520(a)(4)(i), 416.920(a)(4)(i).

Second, if the claimant is not engaged in substantial gainful activity, the Commissioner looks to see “whether the claimant has a severe impairment that significantly limits the claimant's physical or mental ability to perform basic work activities.” *Dixon v. Barnhart*, 353 F.3d 602, 605 (8th Cir. 2003). “An impairment is not severe if it amounts only to a slight abnormality that would not significantly limit

the claimant's physical or mental ability to do basic work activities." *Kirby*, 500 F.3d at 707; *see* 20 C.F.R. §§ 404.1520(c), 404.1521(a), 416.920(c), 416.921(a).

The ability to do basic work activities is defined as "the abilities and aptitudes necessary to do most jobs." 20 C.F.R. §§ 404.1521(b), 416.921(b). These abilities and aptitudes include (1) physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; (2) capacities for seeing, hearing, and speaking; (3) understanding, carrying out, and remembering simple instructions; (4) use of judgment; (5) responding appropriately to supervision, co-workers, and usual work situations; and (6) dealing with changes in a routine work setting. *Id.* §§ 404.1521(b)(1)-(6), 416.921(b)(1)-(6); *see Bowen v. Yuckert*, 482 U.S. 137, 141, 107 S. Ct. 2287, 2291 (1987). "The sequential evaluation process may be terminated at step two only when the claimant's impairment or combination of impairments would have no more than a minimal impact on her ability to work." *Page v. Astrue*, 484 F.3d 1040, 1043 (8th Cir. 2007) (internal quotation marks omitted).

Third, if the claimant has a severe impairment, then the Commissioner will consider the medical severity of the impairment. If the impairment meets or equals one of the presumptively disabling impairments listed in the regulations, then the claimant is considered disabled, regardless of age, education, and work experience. 20 C.F.R. §§ 404.1520(a)(4)(iii), 404.1520(d), 416.920(a)(4)(iii), 416.920(d); *see Kelley v. Callahan*, 133 F.3d 583, 588 (8th Cir. 1998).

Fourth, if the claimant's impairment is severe, but it does not meet or equal one of the presumptively disabling impairments, then the Commissioner will assess the claimant's RFC to determine the claimant's "ability to meet the physical, mental, sensory, and other requirements" of the claimant's past relevant work. 20 C.F.R. §§ 404.1520(a)(4)(iv), 404.1545(a)(4), 416.920(a)(4)(iv), 416.945(a)(4). "RFC is a medical question defined wholly in terms of the claimant's physical ability to perform exertional tasks or, in other words, what the claimant can still do despite his or her physical or mental limitations." *Lewis v. Barnhart*, 353 F.3d 642, 646 (8th Cir. 2003)

(internal quotation marks omitted); *see* 20 C.F.R. §§ 404.1545(a)(1), 416.945(a)(1). The claimant is responsible for providing evidence the Commissioner will use to make a finding as to the claimant's RFC, but the Commissioner is responsible for developing the claimant's "complete medical history, including arranging for a consultative examination(s) if necessary, and making every reasonable effort to help [the claimant] get medical reports from [the claimant's] own medical sources." 20 C.F.R. §§ 404.1545(a)(3), 416.945(a)(3). The Commissioner also will consider certain non-medical evidence and other evidence listed in the regulations. *See id.* If a claimant retains the RFC to perform past relevant work, then the claimant is not disabled. *Id.* §§ 404.1520(a)(4)(iv), 416.920(a)(4)(iv).

Fifth, if the claimant's RFC as determined in Step Four will not allow the claimant to perform past relevant work, then the burden shifts to the Commissioner to prove that there is other work that the claimant can do, given the claimant's RFC as determined at Step Four, and his or her age, education, and work experience. *See Bladow v. Apfel*, 205 F.3d 356, 358-59 n.5 (8th Cir. 2000). The Commissioner must prove not only that the claimant's RFC will allow the claimant to make an adjustment to other work, but also that the other work exists in significant numbers in the national economy. *Eichelberger v. Barnhart*, 390 F.3d 584, 591 (8th Cir. 2004); 20 C.F.R. §§ 404.1520(a)(4)(v), 416.920(a)(4)(v). If the claimant can make an adjustment to other work that exists in significant numbers in the national economy, then the Commissioner will find the claimant is not disabled. If the claimant cannot make an adjustment to other work, then the Commissioner will find that the claimant is disabled. 20 C.F.R. §§ 404.1520(a)(4)(v), 416.920(a)(4)(v). At Step Five, even though the burden of production shifts to the Commissioner, the burden of persuasion to prove disability remains on the claimant. *Stormo v. Barnhart*, 377 F.3d 801, 806 (8th Cir. 2004).

### *The Substantial Evidence Standard*

The Commissioner's decision must be affirmed "if it is supported by substantial evidence on the record as a whole." *Pelkey v. Barnhart*, 433 F.3d 575, 577 (8th Cir. 2006); *see* 42 U.S.C. § 405(g) ("The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive . . ."). "Substantial evidence is less than a preponderance, but enough that a reasonable mind might accept as adequate to support a conclusion." *Lewis*, 353 F.3d at 645. The Eighth Circuit explains the standard as "something less than the weight of the evidence and [that] allows for the possibility of drawing two inconsistent conclusions, thus it embodies a zone of choice within which the [Commissioner] may decide to grant or deny benefits without being subject to reversal on appeal." *Culbertson v. Shalala*, 30 F.3d 934, 939 (8th Cir. 1994).

In determining whether the Commissioner's decision meets this standard, the court considers "all of the evidence that was before the ALJ, but it [does] not re-weigh the evidence." *Wester v. Barnhart*, 416 F.3d 886, 889 (8th Cir. 2005). The court considers both evidence which supports the Commissioner's decision and evidence that detracts from it. *Kluesner v. Astrue*, 607 F.3d 533, 536 (8th Cir. 2010). The court must "search the record for evidence contradicting the [Commissioner's] decision and give that evidence appropriate weight when determining whether the overall evidence in support is substantial." *Baldwin v. Barnhart*, 349 F.3d 549, 555 (8th Cir. 2003) (citing *Cline v. Sullivan*, 939 F.2d 560, 564 (8th Cir. 1991)).

In evaluating the evidence in an appeal of a denial of benefits, the court must apply a balancing test to assess any contradictory evidence. *Sobania v. Sec'y of Health & Human Servs.*, 879 F.2d 441, 444 (8th Cir. 1989). The court, however, does not "reweigh the evidence presented to the ALJ," *Baldwin*, 349 F.3d at 555 (citing *Bates v. Chater*, 54 F.3d 529, 532 (8th Cir. 1995)), or "review the factual record de novo." *Roe v. Chater*, 92 F.3d 672, 675 (8th Cir. 1996) (citing *Naber v. Shalala*, 22 F.3d 186, 188 (8th Cir. 1994)). Instead, if, after reviewing the evidence, the court finds it

“possible to draw two inconsistent positions from the evidence and one of those positions represents the Commissioner’s findings, [the court] must affirm the [Commissioner’s] denial of benefits.” *Kluesner*, 607 F.3d at 536 (quoting *Finch v. Astrue*, 547 F.3d 933, 935 (8th Cir. 2008)). This is true even in cases where the court “might have weighed the evidence differently.” *Culbertson*, 30 F.3d at 939 (quoting *Browning v. Sullivan*, 958 F.2d 817, 822 (8th Cir. 1992)). The court may not reverse the Commissioner’s decision “merely because substantial evidence would have supported an opposite decision.” *Baker v. Heckler*, 730 F.2d 1147, 1150 (8th Cir. 1984); see *Goff v. Barnhart*, 421 F.3d 785, 789 (8th Cir. 2005) (“[A]n administrative decision is not subject to reversal simply because some evidence may support the opposite conclusion.”).

### ***Discussion***

Kinseth argues the ALJ erred in evaluating the medical opinions in the record. First, she argues the ALJ failed to give good reasons for rejecting the medical opinions of her treating physicians. Second, she argues the ALJ erred in giving significant weight to the opinions of the non-examining state agency consultants. For these reasons, she argues the ALJ’s RFC assessment is not supported by substantial evidence.

#### ***A. Evaluation of Treating Physicians’ Opinions***

A treating physician’s opinion is given “controlling weight” as long as it is “well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in [the] record.” 20 C.F.R. § 404.1527(c)(2). A treating physician’s opinion is generally entitled to “substantial weight,” but such an opinion does not “automatically control” because the ALJ must evaluate the record as a whole. *Wilson v. Apfel*, 172 F.3d 539, 542 (8th Cir. 1999). “It is well established that an ALJ may grant less weight to a treating physician’s opinion when that opinion conflicts with other substantial medical evidence contained

within the record.” *Prosch v. Apfel*, 201 F.3d 1010, 1013-14 (8th Cir. 2000). “Moreover, an ALJ may credit other medical evaluations over that of the treating physician when such other assessments are supported by better or more thorough medical evidence.” *Id.* at 1014 (internal quotations and citations omitted). “Whether the ALJ grants a treating physician’s opinion substantial or little weight, the regulations provide that the ALJ must ‘always give good reasons’ for the particular weight given to a treating physician’s evaluation.” *Id.* at 1013 (quoting 20 C.F.R. § 404.1527(c)(2)).

Kinseth argues the ALJ did not provide good reasons for giving little weight to the opinions of Dr. Gibson, Dr. Ahrendsen and Dr. Johnson—her treating physicians. She argues the ALJ’s RFC determination is materially different from Dr. Gibson’s and Dr. Ahrendsen’s opinions and the ALJ failed to give good reasons for discounting their opinions. Moreover, she argues their opinions are consistent with Dr. Johnson’s opinion.

With regard to Dr. Gibson, the ALJ noted that she completed a questionnaire in November 2009. AR 19. Dr. Gibson said she had treated Kinseth since July 2009 for fibromyalgia, osteoarthritis, and chronic headaches. She based her findings on multiple tender points upon examination and degenerative disc disease as evidenced by a MRI of Kinseth’s neck and low back. Dr. Gibson stated Kinseth could not stand or sit for longer than 20 minutes and she could never kneel, climb, crawl, or stoop. *Id.* She also opined that regular attendance and performance would be impaired as well as concentration. AR 558-59. Overexertion could cause a flare up of her fibromyalgia which could result in missed work. Finally, Dr. Gibson noted that Kinseth’s chronic pain was unlikely to improve and would impair her daily function. *Id.* The ALJ gave Dr. Gibson’s opinion “very little weight” stating it was based on a short treating history and was inconsistent with the objective medical evidence in the record. AR 19.

Kinseth argues that a short treating history is not a good reason for discounting Dr. Gibson’s opinion because Dr. Gibson had established an “ongoing treatment relationship” with Kinseth that was long enough for her to make informed opinions.

She also argues that the only objective medical evidence cited by the ALJ as “inconsistent” with Dr. Gibson’s opinion is the MRI, which is not used to diagnose fibromyalgia. The Commissioner argues the ALJ assigned the appropriate weight to Dr. Gibson’s opinion. The Commissioner points out that Dr. Gibson had only seen Kinseth for five months at the time she made her opinion, and later records reveal she had significant concerns about Kinseth’s medications and her requests for early refills. The Commissioner also argues that Dr. Gibson’s opinion was based on Kinseth’s subjective complaints and only includes limitations as described by Kinseth to Dr. Gibson. Finally, the Commissioner suggests that other medical records undercut Dr. Gibson’s opinion, including Dr. Gibson’s own treatment notes and the MRI evidence, which could be used to discredit the severity of other impairments besides fibromyalgia.

Having reviewed the entire record, I find the ALJ provided good reasons, supported by substantial evidence, for giving little weight to Dr. Gibson’s opinion. Dr. Gibson saw Kinseth only four times before giving her opinion. AR 527-30, 534, 542-43. Moreover, it is not clear from Dr. Gibson’s opinion or her treatment notes whether the limitations she provided were her own medical findings or Kinseth’s description of her limitations. AR 527, 558-59. *See Teague v. Astrue*, 638 F.3d 611, 616 (8th Cir. 2011) (concluding the ALJ properly discounted a doctor’s report, in part, because it “cited only limitations based on [the claimant’s] subjective complaints, not his own objective findings.”). I must consider “evidence that supports the ALJ’s decision as well as evidence that detracts from it, but even if inconsistent conclusions may be drawn from the evidence, the agency’s decision will be upheld if it is supported by substantial evidence on the record as a whole.” *Guilliams v. Barnhart*, 393 F.3d 798, 801 (8th Cir. 2005) (citing *Chamberlain v. Shalala*, 47 F.3d 1489, 1493 (8th Cir. 1995)). Because there is substantial evidence supporting the ALJ’s evaluation of Dr. Gibson’s opinion, it should be upheld.

In evaluating Dr. Ahrendsen’s opinion, the ALJ noted that he began treating Kinseth in February 2010 and had not been treating her for “several years” as he

indicated in his March 2011 letter. AR 21. In that letter, Dr. Ahrendsen stated he had been treating Kinseth for ADHD, which had improved with proper medication management. AR 661. However, he stated she still had difficulty focusing and maintaining attention for a long period of time due to the fact that her diagnosis was not made at a young age when it should have been done. *Id.* He stated her bipolar features, chronic depression and chronic back pain also made it difficult for her to focus for a long period of time. *Id.* He wrote, “I believe Kimberly has a sufficient number of medical problems including bipolar issues, depression issues, ADHD issues, chronic back pain issues that her application for disability is a reasonable one.” *Id.* The ALJ remarked that Dr. Ahrendsen had only seen Kinseth a few times since February 2010 and her medication management was transferred to him from Dr. Johnson and Dr. Gibson. AR 21. The ALJ gave Dr. Ahrendsen’s opinions “little weight” stating they were inconsistent with the medical evidence and his own treatment notes which indicated Kinseth was doing better with no reported side effects once she began taking Adderall in February 2010. *Id.*

Kinseth argues the ALJ did not give good reasons for giving little weight to Dr. Ahrendsen’s opinions. First, she argues Dr. Ahrendsen had established an ongoing treatment relationship with Kinseth as defined in the regulations despite his misstatement that he had treated her for several years. Second, she argues that Dr. Ahrendsen’s opinions were not inconsistent with his treatment notes because Kinseth had stated Adderall helped “some” and she stopped taking it in July because it made her feel “weird.” There was also no indication of improvement when she resumed the medication in August 2010. The Commissioner argues the ALJ provided good reasons because Dr. Ahrendsen’s opinions were based on a relatively new treating relationship with Kinseth and his statement that Kinseth has a “sufficient number of medical problems” does not mean she is disabled.

Having reviewed the entire record, I find the ALJ provided good reasons, supported by substantial evidence, for giving little weight to Dr. Ahrendsen’s opinions.

The ALJ correctly pointed out that Dr. Ahrendsen had not treated Kinseth for several years as he claimed. The records show he began treating her in February 2010 and had seen her on approximately seven occasions. AR 618-29. Also, contrary to Kinseth's arguments, the treatment notes show she complained of the drug Strattera in July 2010, saying it made her feel weird, but said Adderall "helps a lot" and she wanted to continue taking it. AR 621. The ALJ's reasons for giving little weight to Dr. Ahrendsen's opinions are supported by substantial evidence in the record.

As for Dr. Johnson, the ALJ acknowledged that he was Kinseth's treating physician for headaches and pain management. AR 19. He wrote a letter for Kinseth in October 2009, stating he did not believe she could work because of her underlying bipolar type II disorder. AR 504. He indicated Kinseth also had chronic pain syndrome, which was no longer under his direct care, but was also debilitating. He explained that Kinseth requires multiple drug therapy for mood stabilization and "with the contingent comorbidities of psychiatric illness and drug side effects, she is unable to perform any type of work at this time." *Id.* He wrote the letter "to document her chronic pain syndrome as well as her history of bipolar depression" and said he supported Kinseth "in filing for disability because of her long-standing debility." *Id.*

The ALJ found Dr. Johnson's opinion "quite conclusory" and stated it provided very little explanation of the evidence relied on in forming the opinion. He noted the opinion appeared to rest on an impairment that is outside his area of expertise and also failed to indicate what clinical findings and objective medical records supported his opinions. Therefore, he gave the opinion no weight.

Kinseth argues Dr. Johnson was familiar with Kinseth's mental condition and had even prescribed medication for her bipolar disorder. She also suggests Dr. Johnson's opinion should have been given greater weight because he considered the combined impact of all her impairments in making his opinion. Finally, she argues Dr. Johnson's opinion is consistent with the medical evidence corroborating her mental condition, including evidence that her chronic pain disorder was associated with

psychological factors, as Dr. Johnson noted. The Commissioner argues the ALJ appropriately assigned Dr. Johnson's opinion no weight, because Dr. Johnson did not consider himself to be Kinseth's treating physician for all her impairments as he repeatedly tried to transfer her to other providers who could better handle some of her impairments. Dr. Johnson also did not outline any clinical findings or cite any objective evidence in support of his conclusions.

Having reviewed the entire record, I find the ALJ provided good reasons, supported by substantial evidence, for giving no weight to Dr. Johnson's opinions. As the ALJ noted, these opinions are conclusory and appear to be based on little medical evidence. *See Stormo v. Barnhart*, 377 F.3d 801, 807 (8th Cir. 2004) ("That a claimant has medically-documented impairments does not perforce result in a finding of disability."); *House v. Astrue*, 500 F.3d 741, 745 (8th Cir. 2007) ("A treating physician's opinion that a claimant is disabled or cannot be gainfully employed gets no deference because it invades the province of the Commissioner to make the ultimate disability determination.").

The ALJ also properly considered that Dr. Johnson did not specialize in mental health. He began seeing her at the headache clinic. AR 383. In discussing possible treatment for bipolar depression and ADHD, Dr. Johnson remarked, "Certainly with her migraine headaches and comorbid mood disorder, this falls under my scope of practice, so I would be comfortable prescribing this if that was necessary." *Id.* While the scope of Dr. Johnson's practice is not clear (his treatment notes indicate he works at Mercy Diabetes Center and Mercy Internal Medicine Clinic), he does not appear to specialize in mental health. The ALJ's reasons are supported by substantial evidence and he did not err in giving no weight to Dr. Johnson's opinion.

The ALJ properly evaluated the medical opinions of Dr. Gibson, Dr. Ahrendsen and Dr. Johnson. He explained the weight given to each opinion and provided good reasons for that weight as required by the regulations. These reasons are supported by

substantial evidence in the record as a whole. The ALJ did not err in evaluating the opinions of Kinseth's treating physicians.

***B. Evaluation of State Agency Consultants' Opinions***

Kinseth argues it is inconsistent for the ALJ to give little weight to some of the treating physicians' opinions on the basis of a short treating history, but give great weight to the opinions of the state agency consultants who have never treated Kinseth. She also points out that one of the state agency medical consultants, Dr. Woodard, specializes in pediatrics,<sup>4</sup> while one of Kinseth's treating physicians, Dr. Gibson, specializes in pain management. She argues the ALJ failed to explain why more weight was given to Dr. Woodard's opinion than Dr. Gibson's. Finally, Kinseth argues Dr. Johnson's opinion should have been given greater weight than any of the state agency consultants' opinions because he considered the combined effect of her mental and physical impairments, while the state agency consultants did not.

The Commissioner argues the ALJ appropriately gave the state agency consultants' opinions significant weight. She asserts the ALJ was required to consider these opinions, and by definition, state agency consultants are "highly qualified physicians, psychologists, and other medical specialists who are also experts in Social Security disability evaluation." 20 C.F.R. § 404.1527(e)(2)(i). She states Dr. Woodard is considered an expert in Social Security disability evaluation by definition, and regardless of her specialty in pediatrics, her findings were affirmed as written by Dr. Griffith, who specializes in internal medicine and family or general practice. Finally, the Commissioner points out that while consultants are limited to considering only physical or mental impairments, they also consider all the evidence in the record, including function reports from the claimant and third parties.

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<sup>4</sup> Dr. Woodard's specialty code "32" is found in Box 32B on the Disability Determination and Transmittal form. AR 56. Specialty code "32" refers to a pediatrician. Social Security Administration Programs Operations Manual System ("POMS") DI 26510.090, *available at* <https://secure.ssa.gov/poms.nsf/lnx/0426510090> (last visited March 15, 2013).

“[T]he opinions of nonexamining sources are generally, but not always, given less weight than those of examining sources.” *Willcockson v. Astrue*, 540 F.3d 878, 880 (8th Cir. 2008). “[B]ecause nonexamining sources have no examining or treating relationship with [the claimant], the weight [the Commissioner] will give their opinions will depend on the degree to which they provide supporting explanations for their opinions.” 20 C.F.R. § 404.1527(c)(3). “[A]n ALJ may credit other medical evaluations over that of the treating physician when such other assessments are supported by better or more thorough medical evidence.” *Prosch v. Apfel*, 201 F.3d 1010, 1014 (8th Cir. 2000) (internal quotations and citations omitted).

In his decision, the ALJ noted the limitations identified by each state agency consultant and also included each of their full narrative assessments. He noted that each opinion was considered as that of a non-treating specialist and he gave each opinion significant weight noting that it was “generally consistent with the record as a whole.” AR 16-21.

The ALJ did not err in giving significant weight to the state agency consultants’ opinions. He reasoned that they were each generally consistent with the record as a whole and demonstrated they were supported by thorough explanations. Although Dr. Woodward specializes in pediatrics, I agree with the Commissioner that Dr. Griffith’s review of Dr. Woodard’s assessment and the evidence is significant as he specializes in internal medicine and general and family practice and affirmed her assessment as written. Finally, the state agency consultants did not consider the combination of Kinseth’s impairments because the regulations do not allow them to. *See* 20 C.F.R. § 404.1615 (“In a case where there is evidence of mental and nonmental impairments and a qualified psychologist serves as a psychological consultant, the psychologist will evaluate only the mental impairment, and a physician will evaluate the nonmental impairment.”). It is the ALJ’s duty to consider the combination of impairments, which the ALJ did here. *See Stormo v. Barnhart*, 377 F.3d 801, 807 (8th Cir. 2004) (“In determining RFC, the ALJ must consider the effects of the combination of both

physical and mental impairments.”). The ALJ’s decision to give significant weight to the state agency consultants’ opinions is supported by substantial evidence.

The ALJ provided good reasons supported by substantial evidence in weighing the medical opinions in the record. The court does not re-weigh the evidence, and the Commissioner’s decision must be affirmed “if it is supported by substantial evidence on the record as a whole.” *Pelkey v. Barnhart*, 433 F.3d 575, 577 (8th Cir. 2006); *Vester*, 416 F.3d at 889 (“we consider all of the evidence that was before the ALJ, but we do not re-weigh the evidence . . .”). In accordance with the regulations, the ALJ assigned a weight to each medical opinion and provided good reasons for giving the medical opinions the weight that he did. These reasons are supported by substantial evidence in the record, and therefore, the ALJ’s decision should be affirmed.

### ***Recommendation***

For the reasons discussed above, I RESPECTFULLY RECOMMEND that the Commissioner’s decision be **affirmed** and judgment be entered against Kinseth and in favor of the Commissioner.

Objections to this Report and Recommendation in accordance with 28 U.S.C. § 636(b)(1) and Fed. R. Civ. P. 72(b) must be filed within fourteen (14) days of the service of a copy of this Report and Recommendation. Objections must specify the parts of the Report and Recommendation to which objections are made, as well as the parts of the record forming the basis for the objections. *See* Fed. R. Civ. P. 72. Failure to object to the Report and Recommendation waives the right to *de novo* review by the district court of any portion of the Report and Recommendation as well as the right to appeal from the findings of fact contained therein. *United States v. Wise*, 588 F.3d 531, 537 n.5 (8th Cir. 2009).

**IT IS SO ORDERED.**

**DATED** this 4th day of April, 2013.



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LEONARD T. STRAND  
UNITED STATES MAGISTRATE JUDGE  
NORTHERN DISTRICT OF IOWA