

TO BE PUBLISHED

**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA
CENTRAL DIVISION**

DIANA JO MEYERHOFF,

Plaintiff,

vs.

MICHAEL J. ASTRUE,
Commissioner of Social Security,

Defendant.

No. C09-3067-MWB

REPORT AND RECOMMENDATION

The plaintiff Diana Jo Meyerhoff seeks judicial review of a decision by an administrative law judge (“ALJ”) denying her application for Supplemental Security Income (“SSI”) under Title XVI of the Social Security Act, 42 U.S.C. § 1381 *et seq.* Meyerhoff claims the ALJ erred in posing an incomplete hypothetical question to the Vocational Expert, and in finding she is not disabled. (Doc. Nos. 10 & 12)

II. PROCEDURAL AND FACTUAL BACKGROUND

A. Procedural Background

On October 8, 2004, Meyerhoff protectively filed an application for SSI benefits, alleging a disability onset date of July 1, 1997. (R. 153-56) The application was denied (R. 65; 71-75), and Meyerhoff did not appeal. On August 19, 2005, she protectively filed another application for SSI benefits alleging the same disability onset date. (R. 158-65; 76-80) That application also was denied (R. 66), and Meyerhoff did not appeal.

On August 17, 2006, Meyerhoff filed a third application for SSI benefits, again alleging a disability onset date of July 1, 1997. (R. 162-65) Meyerhoff claims she is disabled due to arthritis, fibromyalgia, osteoporosis, and “leaking arteries,” all of which

cause her trouble with lifting, standing, and memory. (R. 278) Her application was denied initially and on reconsideration. (R. 67-70; 81-85; 91-94) Meyerhoff requested a hearing, and a hearing was held on January 27, 2009, before an Administrative Law Judge (“ALJ”). (R. 29-33) Meyerhoff appeared without a representative, and she asked for a continuance to obtain representation. The request was granted, and the hearing reconvened on April 9, 2009, at which time Meyerhoff was represented by attorney Ruth Carter. Meyerhoff testified at the hearing, as did Vocational Expert (“VE”) Robert Marquart. (R. 34-64) On May 8, 2009, the ALJ found that although Meyerhoff has some severe impairments, she nevertheless is able to work, and therefore she is not disabled. (R. 11-21) Meyerhoff appealed the ALJ’s ruling, and on August 28, 2009, the Appeals Council denied her request for review (R. 1-3), making the ALJ’s decision the final decision of the Commissioner.

Meyerhoff filed a timely Complaint in this court, seeking judicial review of the ALJ’s ruling. (Doc. No. 3) In accordance with Administrative Order #1447, dated September 20, 1999, 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. Meyerhoff filed a brief supporting her claim on February 19, 2010. (Doc. No. 10) The Commissioner filed a responsive brief on March 29, 2010 (Doc. No. 11), and Meyerhoff filed a reply brief on April 8, 2010 (Doc. No. 12). The matter is now fully submitted, and pursuant to 42 U.S.C. § 405(g), the court turns to a review of Meyerhoff’s claim for benefits.

B. Factual Background

1. Introductory facts and Meyerhoff’s hearing testimony

Meyerhoff was born in 1955, and was 54 years old at the time of the hearing. She last worked full time prior to 2004, as a housekeeper at a Holiday Inn Express. During

that job she experienced some chest pains. She saw a doctor and, according to her, she was diagnosed with heart spasms that were causing her chest pains. (R. 40) She has a prescription for nitroglycerine to address her syncope. (R. 49) When the spasms occur, it “[h]urts very bad,” and feels like she is having a heart attack. Her symptoms subside after she takes the nitroglycerine. (R. 50) Her symptoms are exacerbated by exercise, heat, and humidity. She also is bothered by dust, fumes, and odors. (*Id.*)

Before her housekeeping job, Meyerhoff worked in another cleaning job, for ServiceMaster. Both of the cleaning jobs required her to be on her feet all of the time, do vacuuming and dusting, pick up garbage, clean restrooms, and lift from twenty to fifty pounds. (R. 42) She stated she stopped working altogether due to “burning pains up in [her] upper thighs.” (R. 41)

Meyerhoff was diagnosed with fibromyalgia in 1997, when she was working for ServiceMaster. She began having problems with her elbow that caused her to seek medical attention. That led to a referral to a specialist, who x-rayed her back and diagnosed fibromyalgia. She also has been diagnosed with spinal stenosis. (R. 42-43)

Meyerhoff stated she has pain in her lower back, on the left side of her neck, and along her shoulders. She has been tested for fibromyalgia “trigger points,” which apparently were positive, but to her knowledge there is no treatment for the condition. She did physical therapy and learned some exercises, which she does every day. She takes Tylenol regularly for pain, but she has declined to take any stronger pain medication. She also uses heat at times, which helps her pain somewhat. To alleviate pain in her lower back, she shifts positions at least every ten minutes, and sometimes she has to lie down. (R. 44-45) She can only sit for about ten minutes at a time before she has to change positions, and after sitting for about fifteen minutes, she will get up and move around for awhile until her legs start hurting, when she sits down again. (R. 45)

Meyerhoff also has headaches about three times a week which she believes to be a symptom of her fibromyalgia. When she has a headache, she cannot tolerate bright lights, and she has to sit and rest or lie down. (R. 46) Meyerhoff indicated her neck pain is getting worse, and she believes her spinal stenosis is the cause of her neck pain. (R. 47)

At the time of the hearing, Meyerhoff also was experiencing symptoms from a “possible urinary or bladder problem,” including stomach pains and blood in her urine. She had an upcoming doctor’s appointment to investigate the problem further. (R. 47)

She also has carpal tunnel syndrome on the left side that causes her hand to tingle and affects her ability to hold onto things. She has difficulty opening bottles and jars because of hand weakness. She also has sharp pains in her knees, making it hard for her to walk, and pain in her legs that she treats with Tylenol and heat. (R. 48-49)

Meyerhoff lives with her son, who was thirty years old at the time of the ALJ hearing. He and her younger son, age seventeen at the time of the hearing, do the housework and yard work. Meyerhoff does the cooking, but she has to sit down to cook. (R. 50-51) Her youngest son goes grocery shopping with her because she does not “have the strength to push a cart.” (R. 51)

On a typical day, Meyerhoff has breakfast, and then talks with her daughter or her sister on the phone. She tries to take short walks every day because doctors have indicated walking is good for her fibromyalgia, but she can only walk about a block without stopping due to pain in her legs or her lower back. (R. 51-52) She is not involved in a church or social clubs, and does not leave her home for social functions. She used to help out at her daughter’s school, or be an assistant on the school bus, but she stopped these activities in about 2005, because she developed anxiety attacks when she was around a lot of people. (R. 52) During an anxiety attack, her chest will start hurting, and she will start sweating and shaking. (R. 53) She estimated she has anxiety attacks two to five times a month, and each attack lasts about twenty-five minutes. The attacks are exhausting, and she cannot

continue with her activities immediately after an anxiety attack. She cannot identify anything in particular that brings on an anxiety attack. (R. 53-54) If she has an anxiety attack when she is at the grocery store, her son will help her leave the store. (R. 54)

Meyerhoff did not graduate from high school. She had difficulty learning math and does not work well with numbers, but she reads and writes relatively well. She has memory problems, such as forgetting what month or day it is. (R. 55)

2. Meyerhoff's medical history

Meyerhoff saw Dennis E. Colby, D.O. several times in 1997, with complaints of pain in both arms and elbows, cervical spine muscle spasms and shoulder tenderness, right thigh pain, heel and Achilles tendon pain, left hip and low back pain, and other general medical complaints. (R. 670-76) On April 29, 1997, the doctor noted Meyerhoff indicated she had been having "problems off and on for about 2 years now." (R. 676) He opined she had "more of a strict ligament problem" in her shoulder, but he also noted spasms "in the lower lumbar area as well as the ileosacral junction." (*Id.*) He prescribed hot packs and over-the-counter medications, as well as Daypro, a nonsteroidal anti-inflammatory medication. (*Id.*)

Meyerhoff saw Dr. Colby on January 19, 1998, with complaints of "pains pretty much all over." She reported "pains in her arms, lower back, right shoulder, center of chest, knees, left ear and head." (*Id.*) Dr. Colby diagnosed "Probable Fibromyalgia," and ordered a rheumatoid battery of tests. He also started her on Aleve pending receipt of the test results. (R. 670) Meyerhoff saw Dr. Colby on January 23, 1998, for followup. She reported that Vicoprofen was helping her pain somewhat. Examination revealed muscle spasms in the trapezius and cervical muscles on both sides. She was referred to R. Bruce Trimble, M.D. for consultation. (R. 669)

Meyerhoff returned to see Dr. Colby for followup on February 6, 1998. She exhibited “quite a bit of tenderness . . . in the cervical and trapezius muscles and joints of the shoulders, down into the muscles of the shoulders. This pain extends down into the thoracic area.” (*Id.*) The doctor planned to try to move up the consultation with Dr. Trimble. (*Id.*)

On February 25, 1998, Meyerhoff was evaluated by Rehabilitation Services at Mercy Health Center to receive physical therapy for her back pain, bilateral shoulder pain, and fibromyalgia. On objective testing, she exhibited “increased pain with all movements.” (R. 760) Per instructions from Dr. Trimble, she was instructed in a home exercise program, although the therapist thought she would benefit from other treatment modalities. She tolerated the exercises “fine with no increase or decrease in symptoms.” (*Id.*)

Meyerhoff saw Dr. Colby on March 2, 1998, “stating that Dr. Trimble wanted us to take a look at her and see how she is doing. She is quite sore especially with the physical therapy. Dr. Trimble did agree with our previous diagnosis of fibromyalgia on her. According to the physical therapist they would like to try some traction on her.” (R. 668) Meyerhoff returned to see Dr. Colby on March 6, 1998, “for a consult on her disability.” (*Id.*) She reported having a lot of pain in her upper back and neck, and her arms. Objective examination revealed spasms in the trapezius muscle and in her back. She requested information on SSI. (*Id.*) On March 30, 1998, Dr. Colby prescribed a TENS unit and continued physical therapy. (*Id.*)

On April 3, 1998, Meyerhoff saw the physical therapist at Rehabilitation Services for followup. Notes indicate she had “made a significant amount of progress, but may need monitoring as [she] just received the TENS unit this week.” (R. 759) Meyerhoff was tolerating lumbar traction with hot moist packs well, with good results, but she “did not respond well to attempts to change treatment to manual therapy techniques and

ultrasound.” (*Id.*) Meyerhoff reported that her pain was “significantly decreased” with her TENS unit and home exercises, to a level of 1/10 on the date of her followup. (*Id.*)

On May 13, 1998, Meyerhoff saw Dr. Colby for pain and stiffness in her wrist area. She was diagnosed with wrist inflammation, bicipital tendonitis, and epicondylitis. The doctor prescribed Naprosyn. (R. 667)

On August 5, 1998, Meyerhoff saw Dr. Colby for complaints of pain in her back and depression. She reported severe mood swings and some suicidal thoughts, though no suicidal plans. Examination showed “some spasm . . . in the cervical and trapezius muscle on both sides and down the thoracic area.” (R. 666) She was diagnosed with muscle spasms and depression, and was directed to use hotpacks. The doctor prescribed Naprosyn and Paxil. (R. 665)

On November 13, 1998, Meyerhoff underwent a Functional Capacity Evaluation by Steve Crane, P.T. at Dr. Colby’s request. (R. 753-55) Crane noted the following Positive Findings:

1. Pain affecting both shoulders, bilateral elbows, and left wrist. The patient was overtly sensitive to touch in the left low back and gluteal regions, along with bilateral medial scapular, upper trapezius, and levator musculature.
2. The patient complained of wrist flexor pain with passive wrist flexion. These two are not typically related.
3. Difficulty maintaining one posture for greater than 15 minutes. She is limited in walking to 2 blocks, sitting up to 10 minutes and standing for 5 minutes, according to the patient.
4. Limited cervical side bending bilaterally, but left greater than right. She is limited with left shoulder internal rotation, guarded with trunk range of motion, especially with side bending.
5. The patient has 3/5 strength in the lumbar paraspinal area with prone active extension.

6. Bilateral grip weakness. Bell-shaped curves are displayed with testing, but a relative high coefficient of variance scores are noted.
7. Coordination skills are below normative levels for age and gender, and the patient needed a significant amount of verbal encouragement to increase her pace with testing.
8. The patient demonstrated difficulty with left leg balance skills.
9. The patient's lifting abilities were moderate, although she fatigued quickly at the end of testing, especially with pushing and pulling activities.
10. Two of five Waddell's signs were positive, which was not significant to indicate inappropriate illness behavior.

(R. 753) His assessment indicated Meyerhoff "functioned best with self-pace[d] activities and activities that required a regular change of position." (*Id.*) Dr. Colby reviewed and concurred in the evaluator's recommendations. (*Id.*)

On March 1, 1999, at the request of her attorney, Meyerhoff was seen by L. Frohnauer, Ph.D. "for an outpatient psychological evaluation to rule out depression."

(R. 734-35) He concluded Meyerhoff was "depressed secondary to health, financial and work-related stressors and could benefit greatly from antidepressant medication. Participation in the fibromyalgia support group sponsored by the Womens Health Counseling Center is also recommended." (R. 735)

On June 21, 2000, Meyerhoff saw Dr. Colby for complaints of right upper arm pain, extending down into her arm and fingers, and involving numbness of her fingers. Notes indicate she had not been seen by the doctor since December 2, 1998. Meyerhoff stated her legs became extremely tired when she walked any distance, and when she would drive a car, she would be extremely uncomfortable due to pain in her muscles, shoulders, arms, and back. Examination revealed "[m]arked tenderness and spasm . . . in the trapezius muscle with the right being worse than the left. Range of motion of right shoulder is markedly decreased. Strength is markedly decreased compared to the left.

Cannot abduct the arm and strength is predominantly diminished. Tenderness noted in the thoracic and lumbar paravertebral muscles. Deep tendon reflexes 1 +/4+. Muscles in the lower extremities are tender to palpation.” (R. 661) Dr. Colby diagnosed fibromyalgia “with definite progression from last visit here,” and right shoulder instability. He directed Meyerhoff to continue using over-the-counter anti-inflammatories. He also noted, “In reviewing our chart notes, it is noted she had a [disability] hearing approximately 1 year ago. I do not think she has improved at all from that time, [and] in fact she has gotten worse and continues to be disabled.” (*Id.*)

On June 18, 2002, Meyerhoff saw Dr. Colby to request “an appointment in Iowa City with Internal Medicine for an appointment for the fibromyalgia. Has been trying to get on disability. Has been denied. She has not been able to work. Severe pain pretty much in the major muscles and in the joints, both. This has been quite debilitating for her.” (R. 660) Dr. Colby made Meyerhoff an appointment in Iowa City, but those records do not appear in the Record.

Meyerhoff was seen for right mid back pain on February 13, 2004. (R. 441) Notes indicate she had been diagnosed with fibromyalgia in about 1998, and “[s]he wanted to discuss the fibromyalgia but she doesn’t want any medication for it. She doesn’t want treatment for it. It sounds like her concern is she would like to be on disability for it.” (*Id.*) She was referred to the Mayo Clinic “to see if they can offer her other possibilities for non-pharmacological treatment and application for disability.” (*Id.*)

In March 2004, Meyerhoff was evaluated in a fibromyalgia program at the Mayo Clinic. (R. 426-39) She reported symptoms including diffuse musculoskeletal pain, exercise intolerance, very poor sleep, depression, daily pain and fatigue, headaches, burning pain in her legs, decreased appetite, numbness, stiffness, multiple sensitivities, short-term memory impairment, decreased ability to concentrate and organize thoughts, irritability, and anhedonia. She stated her physical symptoms were aggravated by

prolonged sitting or standing. She indicated her symptoms limited her ability to carry out activities of daily living including homemaking, social, and leisure activities. (*Id.*) She was diagnosed with generalized chronic pain, fibromyalgia, depression, non-restorative sleep, and right chest wall pain. (R. 426, 429) She completed a two-day fibromyalgia treatment program “involving Rheumatology, rehab, physical medicine, and psych” (R. 434), and she received education and materials on the “definition, causes, and treatment of fibromyalgia; stress management, relaxation, sleep hygiene, moderation, self-management concepts, cycle of chronic pain, and difficult day planning.” (R. 427) She also received some occupational therapy to learn “skills to maximize function in activities of daily living and reduce fatigue.” (R. 438) She was instructed in range-of-motion stretching exercises, body mechanics, and aerobic conditioning. (R. 439)

Meyerhoff was seen for right thigh pain on April 27, 2004 (R. 415); left anterior shoulder and chest pain on August 16, 2004 (R. 414); a groin muscle strain on August 27, 2004 (R. 738-41); and right hip and upper leg pain on October 11, 2004 (R. 403). Notes from these visits indicate Meyerhoff was diagnosed with fibromyalgia in 1998, when she was seen by a rheumatologist. She was treated conservatively with Ibuprofen, Tylenol, and Trazodone.

On November 16, 2004, Meyerhoff saw Dr. Trimble for consultation with regard to her complaints of back and leg pain. Dr. Trimble had seen her previously on February 11, 1998, and he “thought she basically had fibromyalgia with some degenerative disk disease at that point.” (R. 399) Meyerhoff stated her pain had remained basically the same, with recent worsening across her back into the right hip area. She was performing normal daily activities. She reportedly would not sleep well, and experienced stiffness for about four hours after awakening in the morning. She occasionally experienced “vague anterior chest discomfort after heavy work which may last the whole day.” (*Id.*) She was taking only Tylenol for her pain. (*Id.*) On examination, Meyerhoff exhibited full range

of motion of all joints. She exhibited tenderness “of lateral epicondyles of the elbows, over a couple proximal interphalangeal joints, around the knees as well as the medial fat pads.” (R. 400)

Dr. Trimble ordered x-rays of Meyerhoff’s lumbosacral spine which indicated “[m]ild degenerative changes of the lower lumbar spine,” and “[m]ild arthritis of the SI joints and hip joints.” (R. 398, 401, 454-55) He started her on Nortriptyline at night, and Naproxen twice daily for pain. (R. 400)

Dr. Trimble saw Meyerhoff for reevaluation of her fibromyalgia on December 16, 2004. Meyerhoff reported sleeping somewhat better on Nortriptyline, and the doctor increased her dosage. He emphasized “the great importance of mild regular exercise, in addition to the need to pace activities and get adequate rest.” (R. 949) He directed her to continue taking Naproxen and Tylenol for pain as needed. (*Id.*)

On December 29, 2004, Stephen Holbrook, Psy.D. conducted a clinical interview and performed a mental status evaluation of Meyerhoff at the request of the state agency. (R. 386-95) Dr. Holbrook noted Meyerhoff “has a limited and sporadic work history,” described as follows:

Reportedly, she has previously worked as a housekeeper at the Lake Mills Care Center for three months with that job ending when she became ill with strep throat and was not granted medical leave. She worked in a seasonal position with a construction company for about three months as a flag person and pilot car driver. She worked for North Central Human Services in Forest City as a residential counselor in a developmentally disabled care center. She left that position feeling she was not given adequate help from other staff members in caring for the disabled individuals. She had worked in a janitorial position with Service Master in Mason City cleaning the corporate offices for a manufacturing plant for approximately three to four months. That job ended in about 1997 due to problems she was having with tendonitis in her arm. For the last year, she has worked for the City of

Joice, Iowa cleaning their Community Center, typically on a once per week, one to two hour basis. She continues in that position as of this date.

(R. 387)

From his mental status evaluation, Dr. Holbrook diagnosed Meyerhoff with Major Depressive Disorder, Recurrent, Mild Severity; Rule out psychological factors that affect underlying medical condition; and he estimated her current GAF at 58. (R. 390) He noted the following summary and conclusions from his evaluation:

[Meyerhoff] is a 49-year old female from Lake Mills, Iowa. She reports a several year history of chronic defuse [sic] pain symptoms as well as problems with arthritis and degenerative disk disease. Her background history is significant for being removed from the home of her parents by DHS when she was 15 years of age and placed with an aunt until the age of 18. Her foster home placement was precipitated by problems with school truancy and poor academic performance. She noted a long history of problems in school with special education programming beginning in about the 8th or 9th grade. Vocationally, she has had a limited work history of rather short-term manual labor types of jobs. She reports a history of problems with depression over the past . . . six to seven years, which has been of relatively stable severity. She has no history of psychiatric hospitalization and denied any history of alcohol or chemical dependency. In terms of depressive symptoms, most notable are problems with depressed mood and sadness, intermittent problems with tearfulness, chronic problems with low energy, problems with some feelings of hopelessness, irritability, and anhedonia. [Her] Beck Depression Inventory Rating falls within the mildly depressed range as does her Hamilton Rating Scale for Depression. She described herself as being relatively independent with her activities of daily living. She appears to be doing well with personal grooming and hygiene. She noted some limitations in her domestic responsibilities due to pain in her leg requiring her to take break[s] and to not stand for long periods of time;

otherwise, she is relatively functional in terms of taking care of herself as well as her 13-year old son.

In terms of work related activities, while she complained of problems with a poor memory and difficulty with concentration, on a conversational basis, she was able to maintain focus and follow the flow of discussion adequately. It is likely that in a work-related position, she would have adequate simple short-term attention and concentration skills, especially with adequate training and rehearsal. Her rate of learning work related responsibilities may be somewhat extended relative to others. Her ability to carry out instructions and maintain adequate attention, concentration, and pace is seen as mildly limited due to psychological factors. Her complaints primarily relate to physical problems with chronic pain. Her ability to interact appropriately with supervisors, coworkers, and the public is likely moderately impaired. It is likely that she is overly sensitive to health related complaints, and she may feel at times that others are unsympathetic. Psychosocial stressors related to marital problems likely play some role in her depression. There is no reported history of impulsive acting out problems or difficulties with impaired judgment. It is likely she can manage her finances independently.

(R. 390-91)

On January 10, 2005, Meyerhoff saw a doctor with complaints of abdominal pain and nausea for three weeks. Notes indicate Meyerhoff had been started on Naprosyn and Nortriptyline in November 2004, for her fibromyalgia, and Meyerhoff had experienced “some mild improvement in her symptoms.” (R. 517) The doctor suspected the Naprosyn and Nortriptyline might be the cause of Meyerhoff’s current symptoms. She discontinued the medications for one week, and prescribed five days of Aciphex and three days of Milk of Magnesia. If her symptoms improved, then other medications would be tried for the fibromyalgia. (R. 518)

On January 11, 2005, Carole Davis Kazmierski, Ph.D. reviewed the record and completed a Psychiatric Review Technique form. (R. 365-79) She found Meyerhoff to

have mild depression that was not severe. In her review comments, Dr. Kazmierski noted the following:

Claimant is a 49 year old woman alleging disability due to lumbar pain, fibromyalgia, disc disease, and depression. Her alleged onset is 10/1/04.

Records from claimant's treating physician make reference to claimant's dysphoric mood and note possible anxiety as responsible for atypical chest pains. Physicians at Mayo Clinic also diagnosed claimant with depression during a March 2004 visit to the clinic.

Claimant was seen for a psychological evaluation on 12/29/04. Claimant reported that she dropped out of high school in her senior year. She reported a history of truancy and a history of learning difficulties with particular problems in math and science courses. Claimant denied a history of psychiatric hospitalization. She feels she has had difficulty with depression for the past 6-7 years, but when questioned stated that she is usually in a pretty good mood. Mental status evaluation found claimant well dressed and well groomed. Claimant followed the discussion well and was logical and coherent in her responses to questions. She could recall 3/3 objects immediately and after a 5-minute delay. She reported chronic problems with low energy, but denied significant anxiety or worrying. Her scores on the Hamilton Rating Scale and the Beck Depression Inventory were both in the mild range of depression. She was diagnosed with a major depressive disorder, recurrent, mild. A rule out diagnosis of psychological factors that affect underlying medical condition was also suggested. Current GAF was estimated at 58.

Claimant lives with her family. She is independent in self-care tasks. She cooks daily and does light household tasks, sharing domestic chores with her daughter. She takes her son to school and picks him up in the afternoon. She manages her own finances and shops independently. She enjoys doing word search puzzles. She talks to her sister on the phone several times a day. She reports that she gets along well with authority figures.

The mental impairment in this case is a major depressive disorder, recurrent, mild. Relevant listing is 12.04. [Medical evidence of record] is limited, but consistent. Although claimant's allegations are generally credible, [medical evidence of record] suggests that claimant's depressive symptoms are relatively mild and do not significantly restrict her daily activities. Although the examining psychologist suggests that claimant might have moderate restrictions in social functioning, there is little evidence to support this degree of impairment. Overall, claimant appears capable of relating to others in a friendly and cooperative manner. She herself notes that she has gotten along fine with authority figures in the past. Available information suggests mild impairment in social functioning.

(R. 379)

On April 14, 2005, Meyerhoff saw her family doctor "feeling dizzy, lightheaded, and nauseous" after "painting a bedroom most of the day." (R. 516) She was diagnosed with vertigo, probably from "the positioning of her head looking straight up at the ceiling while painting." (*Id.*) The doctor opined her symptoms would resolve, and directed her to go to the emergency room if they persisted. (*Id.*)

On April 18, 2005, Meyerhoff was seen for complaints of chest pain and pressure, and a backache. She reported feeling shaky, nauseated, and "down." (R. 507) A chest x-ray was negative (R. 512), and she was scheduled for a stress test. On April 19, 2005, she underwent a stress cardiolute test during which she "exercised for 8 minutes 12 seconds on Bruce protocol. The study was terminated secondary to leg pain." (R. 499) Meyerhoff experienced no chest pain or shortness of breath during the study, and there were "[n]o electrocardiographic changes to suggest any ischemia." (*Id.*) Further testing in April and May 2005, showed no abnormalities in Meyerhoff's heart or lungs. (*See* R. 714-32)

On June 9, 2005, Meyerhoff saw her family doctor with complaints of left-sided neck pain into her shoulder, and low back pain. She exhibited “some discomfort with range of motion of the neck with side-to-side bending, less so with flexion and extension,” but otherwise she had full ranges of motion and no other gross abnormalities were observed. (R. 482) The doctor noted the following from his examination:

Certainly the neck pain could be a combination of the degenerative disk disease as well as fibromyalgia. She seems to have no interest in further followup of the fibromyalgia clinic or with rheumatology. She is not interested in taking any of the medications we had suggested as well as those [another doctor] offered. Possibly if there was a pain clinic in the area, she could consider a referral to that although does not have interest in that either. When we get her radiologist report of the cervical spine x-rays we could then consider proceeding with a referral to neurosurgery if she is interested, although probably would be better served by trying some more conservative measures such as physical therapy and medications rather than going to a surgical option. We will plan to see the patient back in the near future when she has decided which course she wishes to proceed with.

(R. 481)

Meyerhoff returned to see the doctor on July 20, 2005, for followup, and she was referred for a neurosurgical consultation. (R. 480)

Meyerhoff was seen for evaluation by a neurosurgeon on July 27, 2005, with regard to her complaints of neck pain, low back pain, and left leg pain. The doctor noted Meyerhoff’s cervical spine x-rays revealed “extensive degenerative disk disease with some possible spinal stenosis.” (R. 984) He ordered cervical and lumbar MRI studies, and noted she also might need some shoulder x-rays. (*Id.*)

On July 29, 2005, Meyerhoff was seen in the Mercy Medical Center ER with complaints of sweating, nausea, and rapid heart rate. (R. 467-76) She was diagnosed with heart palpitation and an anxiety disorder/panic attack (*see* R. 471, 475), and the doctor

prescribed Ativan, which Meyerhoff declined. (*Id.*) She was discharged home in stable condition. (R. 472) She followed up with her family doctor, and requested a thyroid check, which was done. (R. 478-79)

On August 1, 2005, Meyerhoff again was seen in the Mercy Medical Center ER (R. 456-66) for complaints of cold sweats, rapid heart rate, breathing problems, “pain in neck up to head and in her back,” and a two-week history of low back pain. (R. 459) X-rays of her lumbosacral spine were compared with the November 2004 x-rays, and indicated “[m]ild multilevel degenerative disc disease and lower lumbar facet arthropathy.” (R. 464) She was discharged the same day in stable and improved condition with prescriptions for Naprosyn and Lortab.

On August 9, 2005, x-rays and an MRI were taken of Meyerhoff’s cervical and lumbar spine in connection with her ongoing complaints of back and neck pain. (R. 592-96) Her lumbar spine MRI was largely normal, showing some disc bulges and degenerative changes, but no significant spinal canal stenosis or neural foraminal narrowing. (R. 595-96) The cervical spine scans showed “degenerative endplate marrow changes at C5-6,” with the following impressions:

1. C5-6 and C6-7 broad-based disc bulges with endplate spur formation. This results in canal stenosis and mass effect upon the spinal cord which is shifted posteriorly. The neural foramina at C5-6 are also stenotic.
2. Negative for current cervical cord edema or syrinx formation.
3. Reversal of the normal lordotic curvature. Cervical disc spaces also show diffuse disc desiccation and spondylosis.

(R. 594) The neurosurgeon recommended Meyerhoff return for recheck on about a year “to make sure that she is not developing any significant myelopathy.” (R. 980)

On August 17, 2005, Meyerhoff was seen for complaints that included, among other things, upper abdominal discomfort, weight loss, and menstrual irregularity. The doctor

suggested some of her problems could be due to stress, and Meyerhoff agreed to a trial of the antidepressant Zoloft. On August 29, 2005, Meyerhoff called the office to report that the Zoloft had made her feel suicidal, and she had discontinued it on her own. She reportedly was feeling better after stopping the medication, although she was “still tearful.” (R. 477)

On August 22, 2005, Meyerhoff returned to see her doctor with complaints of epigastric pain that began after she had homemade pizza for dinner. She had cold sweats along with the pain. X-rays of her abdomen were negative, and she was given a “GI Cocktail” and discharged in improved condition. (R. 580-91)

On September 20, 2005, Meyerhoff was seen for complaints of shortness of breath at night and a feeling of something stuck in her throat. Notes indicate Meyerhoff had been complaining to her doctors of shortness of breath for about six months. On this visit, she stated she sometimes became so short of breath that she feared she might pass out, although she was “vague whether this occurs with activity or at rest,” and she was not short of breath at the examination. (R. 570) She also complained of “a stabbing-type chest pain on the right side of her chest,” and “epigastric pain and weight loss.” (*Id.*) The doctor noted Meyerhoff’s records indicated she had undergone a thorough cardiac evaluation that was negative, and an upper GI series that was normal. Meyerhoff admitted to experiencing a great deal of stress related primarily to her financial situation and being homeless, and indicated she might be willing to undergo some counseling. Notes indicate “she probably does need someone to talk to and find some other way to deal with the stresses as she is intolerant to medications, even in small doses.” (*Id.*) Notes further indicate Meyerhoff declined psychiatric hospitalization, indicating she was not suicidal or homicidal. She did not have reliable transportation to get to counseling, but was unwilling “to move forward with other avenues for getting to where counseling would be available.” (R. 600)

Meyerhoff saw Nancy A. Knudtson, A.R.N.P. on October 3, 2005, for concerns regarding unintentional weight loss of twenty to thirty pounds since April 2005. Several lab tests were ordered, and Meyerhoff was encouraged to increase her caloric intake as much as possible. (R. 806-07) Meyerhoff was seen on October 10, 2005, for followup on her lab work. All of her lab results were normal. She was advised to quit smoking, and she was referred to an internal medicine specialist for evaluation regarding her weight loss and fatigue. (R. 802)

On October 18, 2005, Meyerhoff saw a nurse practitioner with complaints of the “loss of some of her eyebrows over the last few days,” and also a concern about weight loss of about thirty pounds since April 2005. (R. 800) She was referred to a medical internist for consultation. Notes indicate Meyerhoff declined a prescription for antidepressants. (*Id.*)

On October 21, 2005, Meyerhoff saw Bruce Harlan, M.D. with a concern that she had lost thirty pounds over the past seven months. Meyerhoff “readily admit[ted] to significant depression,” which she rated at 10 on a 10-point scale. Dr. Harlan indicated her weight loss was “probably psychiatric in origin,” and he started her on Remeron at bedtime. He encouraged her to increase her daily caloric intake and to quit smoking. (R. 946-47)

On October 27, 2005, Stephen Holbrook, Psy.D. conducted a clinical interview, mental status evaluation, psychological testing, and reviewed Meyerhoff’s treatment records, as a followup to his December 2004 evaluation. (R. 558-69) His diagnostic impressions included “Major Depressive Disorder, Recurrent, Moderate Severity; Rule out Psychological Factors Underlying Medical Condition.” (R. 568) He estimated her current GAF at 53. Dr. Holbrook noted the following summary and conclusions:

Diana Meyerhoff is a 50-year-old divorced female from Lake Mills, Iowa. She reports a several year history of pain symptoms, which she relates to numerous underlying medical

conditions. Her background history is significant for a chronically dysfunctional marriage with a history of physical and verbal domestic abuse by her alcoholic ex-husband. She has had recurrent problems with depression for a number of years. She has not been involved in any specialized psychiatric or psychological treatment. She continues to be resistant towards psychological and/or psychiatric treatment. She has been followed by her primary care physicians. She currently is not taking any prescribed psychotropic medications. She remains very hesitant to pursue any mental health counseling. She has very negative views regarding taking medication in general. In terms of her presentation, her depressive symptoms are worse relative to those of December 2004. She continues to have difficulties with depression, sadness, and problems with low energy, hopelessness, helplessness, apathy, and anhedonia. While she complains of significant problems with her attention span and general memory, formal testing reveals Low Average to Average skills in those areas. She does have some degree of weakness in terms of active working memory skills, but otherwise generally Average memory abilities.

In terms of work related activities, it is likely that she would be able to remember and understand work-related instructions and procedures and locations with adequate learning. It is likely that in a work related position, her simple short term attention and concentration skills would be adequate. Her ability for sustained attention and concentration skills and pace is likely moderately limited due to her psychological factors. Her ability to interact appropriately with supervisors, coworkers, and the public continues to likely be moderately impaired due to her apathy and pessimism.

(R. 568-69)

On October 28, 2005, Mark D. Dankle, D.O. examined Meyerhoff at the request of the state agency. (R. 550-57) Meyerhoff reported current symptoms including chronic fatigue, weight loss due to stress, intermittent blurred vision, chronic tinnitus; neck, chest, and back pain; chronic cough related to smoking; some shortness of breath; occasional

abdominal discomfort; lightheadedness if she stood too quickly; generalized weakness and shakiness; poor sleep; problems with anxiety and depression; and seborrhea on her face. (R. 551) After performing a physical examination, including testing Meyerhoff's ranges of motion and conducting a fibromyalgia evaluation, Dr. Dankle assessed Meyerhoff with "[c]hronic pain in her neck, back, left arm, and left leg"; "[h]istory of fibromyalgia"; and "[p]ossible valvular heart disease." (R. 552) He noted the following:

In regards to her remaining physical capacity and limitations, I would recommend that she avoid heavy lifting and carrying. I believe that she is capable of lifting and carrying 20 pounds on occasion. I see no limitations with regards to standing, moving about, walking, or sitting. I see no limitations with regards to stooping, climbing, kneeling, or crawling. I see no limitations with regards to handling objects, seeing, hearing, speaking, traveling, or work environment. I see no limitations with regard to handling cash benefits.

(Id.)

On November 12, 2005, a consulting physician reviewed the record and completed a Physical Residual Functional Capacity Assessment form. (R. 523-30) The consultant opined Meyerhoff would be able to lift twenty pounds occasionally and ten pounds frequently; and sit, stand, and walk for about six hours each in an eight-hour workday, with no restrictions on her ability to push or pull. (R. 524) She should never perform balancing activities, but could perform all other postural activities occasionally. (R. 525) The consultant's review notes include the following:

This 50 year old claimant is alleging disability due to arthritis in neck and back, osteoporosis, leaking arteries and depression. For review of medical records and assessment at previous filing, the reader is directed to RFC in file dated 12/29/04 as that information will not be repeated here. Since that filing the claimant has sought treatment on occasion for chest pain but a subsequent stress test was negative. She has also sought treatment for abdominal pain which was felt to be GERD and was started on medication. She has also continued

to be seen for joint and muscle pain. She was referred to a neurosurgeon but surgery was not elected at this point. A[n] MRI of lumbar and cervical spines in 8/05 indicated DDD and disc bulges at various joints. She was sent to a consultative examination in 10/05. She had normal ROM, strength, sensation, reflexes and gait. She did have multiple trigger points tender in upper back and neck. Examining source statement given. She indicates chronic pain 24/7. She takes no medications for pain. She indicates exercises make it worse. She can't walk 1/2 block and can only stand few minutes and sit for 15 minutes. She is currently homeless. She lives at her son[']s during the night and sister's during the day. She cares for son. She drives daily, makes her own meals and does laundry. Limitations are consistent with objective evidence and daily activities she is currently performing.

(R. 531) On December 13, 2005, Dr. Jeffrey Wheeler reviewed the record and concurred in the findings of the November 12, 2005, evaluation. (R. 531-32)

On November 16, 2005, Beverly Westra, Ph.D. reviewed the record and completed a Psychiatric Review Technique form. (R. 533-46) She found Meyerhoff to have Major Depressive Disorder, moderate, but opined the impairment was not severe. She opined Meyerhoff would have mild difficulties in maintaining concentration, persistence, or pace, but otherwise would not be limited by mental impairments. (R. 543; *see* consultant's review comments at R. 545) On December 14, 2005, Philip Rosenshield reviewed the record and concurred in Dr. Westra's findings. (R. 547-48)

On January 9, 2006, Meyerhoff saw Nurse Knudtson for complaints of left upper arm pain, worsening over the previous couple of years. Meyerhoff stated her discomfort was constant, and sometimes, though rarely, the pain radiated toward her shoulder or elbow. The pain worsened with almost any movement of her arm, and was less when she kept her arm immobile. She was not taking any pain medications, stating Tylenol and Ibuprofen made her sleepy. She also was not using any heat or ice for discomfort. Nurse

Knudtson consulted with a physician, and then recommended physical therapy for a month. She also recommended Meyerhoff take Ibuprofen 200 mg three times daily. Meyerhoff also mentioned she planned to try to quit smoking. (R. 797) On January 11, 2006, Nurse Knudtson notified Meyerhoff of the results of left shoulder x-rays, which apparently were unremarkable as Meyerhoff was “[a]dvised to continue with physical therapy.” (R. 794) Meyerhoff saw the physical therapist several times, attempting several therapies including electrical muscle stimulation, ultrasound, and several range-of-motion exercises to strengthen her left shoulder. Her average range of motion with shoulder abduction and flexion was 90 degrees, although she experienced pain ranging from 6 to 8 on a 10-point scale. Her strength was limited by her pain. She did not show significant change from her first visit to her last, and the physical therapist suggested an orthopedic consult might be appropriate. (R. 818)

On February 14, 2006, Meyerhoff was seen in the emergency room for complaints of chest pain, which had been waxing and waning over the previous three days. The pain was on the left side, both anterior and superior, and radiated into her arm. X-rays were negative for any cardiopulmonary problem. She was diagnosed with chest wall pain and was discharged in stable condition. (R. 680-89)

Meyerhoff was seen by Nurse Knudtson for complaints of left upper arm and shoulder pain on February 24, 2006. She was referred to a physician’s assistant for consultation, and was directed to take Aleve for pain. (R. 788-90)

On February 28, 2006, Meyerhoff was seen by a physician’s assistant “with chief complaint of left shoulder discomfort,” which had bothered her for about two years. (R. 787) She indicated she experienced a lot of discomfort with overhead activities and with lifting objects. She had undergone physical therapy for the previous month without any significant relief, although she admitted she had missed several appointments and had not gone on a consistent basis. She was directed to try 800 mg of Ibuprofen three times

daily for two weeks, with a plan to pursue a Depo-Medrol injection if the Ibuprofen failed to relieve her symptoms. (R. 785-87)

On March 21, 2006, Meyerhoff saw a doctor “for followup of her neck and low back pain.” (R. 975) Meyerhoff complained of “diffuse aching in her neck, back, arms and legs.” (*Id.*) On examination, she exhibited good strength, gait, and station; brisk reflexes at the arms and ankles; and no remarkable findings. She was directed to follow up as needed, and the doctor suggested she could see a doctor at the Rehabilitation Clinic for further treatment of her fibromyalgia, if desired. (*Id.*)

Meyerhoff was seen by the P.A. for followup of her left shoulder pain on March 28, 2006. Notes indicate that “[u]pon examination, she had symptoms consistent with impingement syndrome.” (R. 784) She did not want to proceed with injections, and was advised to take Ibuprofen 800 mg three times daily. (R. 782-84)

On May 11, 2006, Meyerhoff saw Nurse Knudtson for followup of her shoulder pain and “Fibromyalgia/Fibromyositis.” (R. 781) Meyerhoff requested a referral for a second opinion regarding treatment for her shoulder pain. She was reluctant to take Ibuprofen or to receive Depo-Medrol injections proposed by doctors. She was referred to Leonard Shelhamer, M.D. for a consultation. (R. 780-81)

Meyerhoff saw Dr. Shelhamer on May 19, 2006, for followup of her fibromyalgia, and complaints of sleep disturbance, chronic fatigue, and depression. Dr. Shelhamer advised her that in his experience, “fibromyalgia patient’s [sic] never get better unless they quit smoking,” and she was advised to quit smoking. (R. 777) He recommended a regular exercise program, a combination of medications, and counseling to help her deal with the emotional aspects of her illness. He then noted the following:

Unfortunately, the patient is reluctant to pursue any of the above options. This is not only a pattern that she has exhibited in the past but it is quite common with fibromyalgia patient’s [sic]. She was given the option of either coming back to discuss this further if she would like to pursue any of the

recommendations, or perhaps contacting Nancy Knudtson, A.R.N.P. in Lake Mills, who could follow the recommendations outlined above.

(R. 777-76)

On July 25, 2006, Meyerhoff was seen for complaints of joint pain, shoulder pain, and limb pain. She stated she had seen two orthopedic doctors about her shoulder pain and had received two different opinions, and she wanted an MRI of her shoulder before going forward with cortisone shots. She stated the “pain in her upper arm has not gotten worse or better over the past few years.” (R. 767) An MRI was scheduled, and Meyerhoff was “highly encouraged . . . to quit smoking.” (R. 768) Meyerhoff returned for followup on August 11, 2006. She apparently had had the MRI of her shoulder, which showed “significant rotator cuff inflammation.” (R. 771) Dr. Michael Eckstrom opined she had “a large partial tear, if not a full thickness tear” of the rotator cuff.” (*Id.*) Meyerhoff finally agreed to try an injection, and she returned on August 15, 2006, for the injection. (R. 773) She also was referred for physical therapy. (R. 775) She was directed to return for followup in six weeks. (*Id.*)

Meyerhoff was seen by a physical therapist on August 18, 2006. She reported that the injection she had received on August 15th “was of very minimal help.” (R. 821) Examination revealed “findings . . . consistent with the diagnosis of the chronic shoulder pain.” (R. 822) The therapist noted Meyerhoff had “definite postural weakness causing increased impingement of the shoulders with movement.” (*Id.*) She opined that Meyerhoff’s rehabilitation potential was good, but she noted Meyerhoff would have to be consistent with her home exercise program in order to achieve her full potential. (*Id.*)

On November 27, 2006, Meyerhoff was seen at the Mason City Clinic Heart Center for evaluation of her complaints of chest pain. (R. 824-25) The doctor’s impressions included “Atypical chest pain, most likely related to fibromyalgia”; “Mild mitral and tricuspid insufficiency”; and “Fibromyalgia.” (R. 825) Meyerhoff was scheduled for a

stress echocardiogram. (*Id.*) The echocardiogram apparently “showed possible anterior apical ischemia” (R. 834), and Meyerhoff was scheduled for an angiogram.

On December 18, 2006, Meyerhoff was evaluated by Mark D. Dankle, D.O. at the request of the state agency. (R. 828-33) Dr. Dankle opined Meyerhoff would be able to lift ten to twenty pounds occasionally, but she should “avoid heavy lifting and carrying.” (R. 830) He indicated she could “stand, move about, walk, and sit at her tolerance [but] likely will need to change positions on a regular basis.” (*Id.*) He recommended she “avoid stooping, climbing, kneeling, [and] crawling,” but she could handle objects, see, hear, speak, and travel without limitations, and she would have no work-related environmental limitations. (*Id.*) Dr. Dankle found no fibromyalgia positive tender points. (R. 833)

On December 27, 2006, Meyerhoff underwent an angiogram, and she “was found to not have any significant disease. Her chest pain was not felt to be cardiac in nature.” (R. 834)

On January 19, 2007, Meyerhoff was seen by Carroll D. Roland, Ph.D. for a psychological evaluation at the request of the state agency. (R. 839-43) Dr. Roland noted “multiple indications of severe major depression.” (R. 842) She suggested Meyerhoff be evaluated by a mental health professional because her depression was unlikely to resolve itself spontaneously. Although Meyerhoff stated she “[d]id not believe in the use of medication and avoid[ed] medication unless absolutely necessary,” she did agree to contact a local mental health center for evaluation. (R. 842) Dr. Roland noted the following conclusions and diagnosis:

Diana Meyerhoff is a 51-year-old divorced Caucasian female with a major depressive disorder and a panic disorder with agoraphobia. She has a history indicating subaverage intellect, albeit the extent unknown. She has not been competitively employed since 1997. Prior to that, she worked for a short time with a cleaning service and averaged 30 hours a week.

Memory is sufficient for entry level competitive employment. Her ability to work outside of the home is currently compromised by her agoraphobia. She has been referred to a mental health center for evaluation and treatment. ADL's are limited due to her fibromyalgia and various medical conditions. She requires assistance with normal ADL's and is unable to balance a checkbook. She pays bills with cash and money orders. Should she be determined eligible for the receipt of disability income, a payee is not needed as applicant is willing to turn to others for advice. She is not deemed capable of handling the stress of entry level competitive employment until at such time as her depression and panic disorder are brought under control.

Diagnosis:

Axis I: Major depressive disorder, single episode with moderate intensity (DSM IV: 296.22)

Axis II: None.

Axis III: Fibromyalgia, osteoporosis, degenerative disc disease, valvular heart disease, recurrent headaches by history.

Axis IV: Multisystem health problems, primary support, economic.

Axis V: Current GAF: 50-55.

(R. 843)

On February 10, 2007, Dee Wright, Ph.D. reviewed the record and completed a Psychiatric Review Technique form (R. 846-59), and a Mental Residual Functional Capacity Assessment form (R. 860-63). Dr. Wright opined Meyerhoff would be moderately limited in the ability to understand, remember, and carry out detailed instructions; maintain attention and concentration for extended periods; 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; perform at a consistent pace without an unreasonable number and length of rest periods; interact appropriately with the general public; and respond appropriately to changes in the work setting. No other restrictions were noted in Meyerhoff's mental work-

related abilities. (*Id.*) Dr. Wright noted Meyerhoff “would have difficulties with cognitive tasks that involve high levels of abstract reasoning,” but she would be “able to sustain a range of simple, repetitive, and routine cognitive activities without significant limitations of function.” (R. 862) Dr. Wright further opined Meyerhoff “would have difficulty consistently performing complex cognitive activity that demanded prolonged attention to minute details and rapid shifts in alternating attention,” but she is able to travel independently, and she could “sustain short-lived, superficial interaction with others in appropriate ways when it is a perceived interest to do so.” (*Id.*) Dr. Wright concluded that although Meyerhoff has diagnosed medically-determinable mental impairments that create some limitations of function for her, none of her limitations meets or equals the Listing level of severity. (*Id.*)

On February 12, 2007, Rene Staudacher, D.O. reviewed the record and completed a Physical Residual Functional Capacity Assessment form (R. 864-71). Dr. Staudacher opined Meyerhoff would be able to lift up to twenty pounds occasionally and ten pounds frequently; stand, walk, and sit for about six hours in an eight-hour workday; and perform all postural activities occasionally. The doctor noted Meyerhoff was reluctant to undergo medical treatment for her fibromyalgia, and she had only four fibromyalgia tender points, which did not “meet the criteria for the American College of Rheumatology classification for fibromyalgia.” (R 866) The doctor found Meyerhoff’s claims that she can only walk half a block, stand ten minutes, lift ten pounds, and sit for ten to fifteen minutes, to be inconsistent with objective exam findings and her activities of daily living. (*Id.*)

On February 12, 2007, Meyerhoff met with Nurse Knudtson to discuss smoking cessation options. Meyerhoff had cut back to only three cigarettes per day, and she was feeling somewhat anxious. She was started on Wellbutrin. (R. 892)

On April 5, 2007, Meyerhoff was seen for evaluation of abdominal pain. (R. 888-90) Records indicate she currently was taking Wellbutrin, 150 mg twice daily;

Nitroglycerin as needed for chest pain; Ibuprofen, 200 mg as needed; and Acetaminophen, 1,000 mg as needed. (R. 890) An ultrasound of her abdomen showed “a left renal cyst.” (R. 887) She was referred to a surgeon for consultation. (R. 885)

On April 10, 2007, neurosurgeon Darren S. Lovick, M.D. saw Meyerhoff for consultation with regard to “bulging disks and stenosis.” (R. 882, 974) The doctor explained to Meyerhoff that her “broad-based bulging disks and findings [were] normal as one gets older and certainly nothing surgical. There are no neurosurgical issues in her care.” (*Id.*) He indicated there was nothing surgically that could be done to help Meyerhoff’s pain, and her only restrictions would be “guided by pain and tolerance.” (R. 881) He suggested she see a pain doctor for her pain. (*Id.*)

On April 18, 2007, Meyerhoff was seen for evaluation of a renal cyst found during an abdominal ultrasound. Further evaluation with endoscopy was recommended. (R. 959)

On May 10, 2007, James D. Wilson, M.D. reviewed the record and completed a Physical Residual Functional Capacity Assessment form. (R. 903-10) His opinions were identical to Staudacher’s assessment from February 2007. (*See* R. 864-71) Dr. Wilson found that Meyerhoff’s latest back exam, which was within normal limits, partially eroded the credibility of Meyerhoff’s claim that she is limited by back pain. (R. 908)

On June 8, 2007, Jane Bibber, Ph.D. reviewed the record and completed a Mental Residual Functional Capacity Assessment form (R. 911-14). She affirmed Dr. Wright’s February 10, 2007, assessment, noting Meyerhoff had no mental limitations in her activities of daily living. (R. 913)

On July 13, 2007, Meyerhoff saw Nurse Knudtson with complaints about neck and back pain, radiating into her lower back somewhat. She also complained of having “quite a bit of anxiety and feeling down in the dumps[.]” (R. 935) She was started on Lexapro for the depression, and was encouraged to go to the fibromyalgia clinic. She also was told to use ice or heat, and take Ibuprofen as needed. (R. 935-36) Meyerhoff was still

smoking about three cigarettes per day, and she was encouraged to quit smoking altogether. Nurse Knudtson provided her with some smoking cessation materials. (R. 937)

Meyerhoff was seen for followup of her depression on August 3, 2007. She reported that Lexapro was helping her mood swings. She also reported that physical therapy was helping her neck pain and fibromyalgia symptoms. She was continued on Lexapro without change, and directed to continue physical therapy. Notes indicate the nurse practitioner encouraged Meyerhoff to consider counseling but Meyerhoff declined. (R. 932)

On September 11, 2007, Meyerhoff saw a nurse practitioner with complaints of neck pain, radiating down into her right flank area and causing headaches. She stated the pain had begun about two weeks earlier, and Tylenol was not helping the pain. She was given a prescription for Flexeril, and directed to continue taking Tylenol or Ibuprofen as needed. (R. 930)

On October 4, 2007, Meyerhoff saw Dr. Trimble for consultation with regard to her complaints of musculoskeletal discomfort and constant pain throughout her body. Meyerhoff believed her pain was worsening. She reportedly was doing conditioning exercises at home, and she was taking Ibuprofen and Tylenol as needed. Dr. Trimble diagnosed her with fibromyalgia, depression, and “some tendinitis along the iliac crest.” (R. 943) He noted the following:

Long discussion about fibromyalgia. Emphasized the importance of rest, adequate treatment of depression, and a regular exercise program. Emphasized that she has no evidence of true rheumatologic disease.

I asked her to get back on her Wellbutrin on a regular basis. Take Tylenol on a regular basis. I did give her a prescription for Gabapentin 300 mg, one to two nightly for what may be restless legs. I will have physical therapy do ultrasound over Hydrocortisone paste to the iliac crest.

(*Id.*) Dr. Trimble also ordered several lab studies, and directed Meyerhoff to return for followup in one month. (*Id.*)

Meyerhoff returned for followup on November 16, 2007. Dr. Trimble's notes indicate he had seen Meyerhoff on and off for her diagnosis of fibromyalgia "for ten years or so." (R. 984) She was sleeping somewhat better with Gabapentin for restless leg syndrome, but she was still stiff and tired in the mornings. Her depression was stable. Meyerhoff reported that she was "in a retraining workshop, and hope[d] to do at home medical transcription." (*Id.*) Dr. Trimble noted the following conclusions:

Again had a long discussion with her about the nature of fibromyalgia, lack of a definitive treatment, the importance of controlled depression, adequate sleep, and a regular physical activity program. Told her that people do not generally do any better if they are not working. She does seem motivated to work but she will have some permanent restrictions. She should not work more than 8 hours a day, 40 hours a week. She should be allowed periodic breaks, should not do repetitive lifting or squatting, should not lift more than 20 pounds, and should not do repetitive work with the hands, other perhaps than typing/computer work.

(R. 964-65) He increased Meyerhoff's Gabapentin dosage, and suggested a trial of Lyrica.

(R. 965)

Meyerhoff saw Nurse Knudtson on December 5, 2007, with complaints of right hip and low back pain since the morning of December 1, 2007. She stated the discomfort was worse when she sat or walked, and better when she was lying down. She asked for "a note to excuse her from a class that she was supposed to attend yesterday." (R. 1018) She had somewhat limited range of motion of her right hip due to discomfort, and was tender to palpation in the right hip area. Nurse Knudtson prescribed Lortab, and ice or heat for fifteen minutes every couple of hours. She encouraged Meyerhoff to get a flu shot, which Meyerhoff declined, and she strongly encouraged her to quit smoking. (R. 1018-20)

On March 10, 2008, a doctor wrote a work release for Meyerhoff to return to work with no restrictions. (R. 1017)

On July 14, 2008, Meyerhoff saw Nurse Knudtson with complaints of low back pain and left knee pain. Notes indicate Meyerhoff had had “a flare up” a week earlier, “and actually had to miss work a couple of days.” (R. 1010) Meyerhoff was requesting a note to excuse her for those two days off work. (*Id.*) Nurse Knudtson recommended Meyerhoff increase her Tylenol dosage and use either ice or heat, whichever felt better, to relieve her discomfort. X-rays were ordered. (R. 1011) Nurse Knudtson also wrote Meyerhoff a work release for July 7 and 8, 2008. (R. 1013)

On August 13, 2008, Nurse Knudtson wrote a letter to Meyerhoff indicating x-rays of Meyerhoff’s lumbar spine showed “some degenerative joint disease.” (R. 1009) Nurse Knudtson recommended a course of physical therapy. (*Id.*)

Meyerhoff next saw Dr. Trimble on August 27, 2008. She reportedly was babysitting some grandchildren in the evening. She was doing her own housework, but avoiding “the heaviest yard and garden work.” (R. 962) She was taking one or two Tylenol daily for pain. She had stopped taking Gabapentin on her own, and also was not taking any antidepressant medications. She was sleeping poorly at night, having discomfort in her shoulder, and walking sporadically for exercise. She also was using a Theraband for some exercises, and her back pain and tendinitis around the iliac crest had improved. On examination, she had full ranges of motion, although she experienced discomfort on extremes of motion and exhibited tenderness in her neck and shoulders, and around both elbows and knees. Dr. Trimble recommended Meyerhoff receive “more expert attention to the depression,” and he suggested she contact the mental health clinic for evaluation. He prescribed Tramadol and Tylenol for her fibromyalgia, and again emphasized the importance of mild regular exercise such as walking. (R. 963)

Meyerhoff saw a counselor for evaluation on September 4, 2008. (R. 966-69) Meyerhoff described her history of depression and anxiety. She stated she did not feel she was capable of working at the present time. She was diagnosed with “depression due to fibromyalgia,” and her current GAF was estimated at 50. (R. 968) Meyerhoff “seemed a little bit miffed by the referral from Dr. Trimble to psychiatry,” and stated her symptoms were not “significant enough to warrant any further either therapy intervention or medication intervention so she [turned] down referral to staff psychiatry.” (R. 968-69)

On September 24, 2008, Meyerhoff was seen by David W. Beck, M.D. for a neurosurgical consultation on referral from Dr. Trimble. Dr. Beck found Meyerhoff to be “intact” neurologically. He explained there was no surgical intervention that could help her, although he noted “[s]he may require surgery in the future because of spinal stenosis.” (R. 973) He started her on Lyrica and “sent her to therapy.” (R. 972) He noted Meyerhoff would have “no formal restrictions of her lifting, carrying, standing, stooping, walking, kneeling[,]” and her restrictions would be “guided by pain and tolerance.” (R. 973)

On October 30, 2008, Meyerhoff saw Nurse Knudtson with a complaint of “bilateral upper inner thigh pain off and on for a couple of years which seems to be getting worse.” (R. 107) She was told to take Extra-Strength Tylenol as needed for pain; to exercise thirty to sixty minutes a day; and to continue doing her back range-of-motion exercises. (*Id.*)

On January 15, 2009, Meyerhoff was seen for a health maintenance exam. Notes indicate, among other things, that Meyerhoff felt well, had a good energy level, and tolerated exercise well. (R. 1000) After a complete examination, the doctors’ assessment was fibromyalgia and nicotine dependence. Meyerhoff was encouraged to stop smoking. (R. 1002)

On January 23, 2009, Meyerhoff saw Dr. Trimble with a complaint of tingling in her hands, particularly the left. He diagnosed her with “relatively mild carpal tunnel symptoms on the left,” and prescribed a splint to be worn nightly for four to six weeks and then periodically as needed. (R. 993)

On March 4, 2009, Anita Eshelman-Peters, M.D. wrote to Meyerhoff with the results of a mammogram and bone density test. A followup mammogram was recommended on the right, *see* R. 1021, and the bone density test showed “some early thinning of the bone.” (R. 997) Meyerhoff was advised to stop smoking and take vitamin supplements to slow her bone loss. (*Id.*)

On April 7, 2009, Dr. Eshelman-Peters completed a Treating Medical Source Statement (R. 1029-34) She indicated Meyerhoff had been a patient at the clinic since 2005, and her primary diagnosis was chronic musculoskeletal pain. The doctor characterized Meyerhoff’s prognosis as “fair,” and indicated she has chronic pain, predominantly in her back, worse with sustained position of over fifteen minutes at a time, and compromising her daily life. She indicated Meyerhoff’s ranges of motion are “impaired,” but she does not have significant limitation of motion. She indicated Meyerhoff has headaches an average of three times per week that are accompanied by photosensitivity, exhaustion, inability to concentrate, visual disturbances, and impaired appetite. The doctor further indicated that although emotional factors contribute to the severity of Meyerhoff’s symptoms and functional limitations, Meyerhoff has “no known” psychological conditions that affect her physical condition. (R. 1030-31)

The doctor opined that Meyerhoff’s pain and other symptoms would interfere with her attention and concentration on a constant basis. She opined Meyerhoff would be able to sit for no more than fifteen minutes at a time, stand for no more than ten to fifteen minutes at a time, sit and stand/walk for a total of less than two hours in a normal workday, and walk less than one block without rest or severe pain. Meyerhoff would need

to walk around every fifteen minutes during a workday for about ten minutes at a time, and she would require a job that allows shifting of positions at will from sitting, standing, or walking. She would need unscheduled breaks to lie down every ten to fifteen minutes, lasting ten minutes at a time. The doctor further opined Meyerhoff would be able to lift less than ten pounds occasionally and ten pounds rarely; she could twist, climb stairs, and hold her head in a static/neutral position occasionally; rarely stoop/bend and crouch/squat; and never look down (sustained flexion of her neck), turn her head right or left, look up, or climb ladders. She further indicated Meyerhoff should avoid exposure to excessive heat or humidity, odors, dust, and fumes. (R. 1032-33) She opined Meyerhoff would be absent from work more than four days per month. (R. 1033)

3. *Vocational expert's testimony*

The VE stated that a review of Meyerhoff's work history shows she has worked in general housekeeping, some commercial cleaning, and as a flagger, all of which are unskilled jobs, but none of her work was at the substantial gainful activity level. (R. 58)

The ALJ asked the VE the following hypothetical question:

Could you please assume a hypothetical individual, . . . and this hypothetical, this first hypothetical individual is limited exertionally to the performance of no more than light work activity. This individual could lift and carry up to 10 pounds, up to 20 pounds occasionally, 10 pounds frequently; stand and walk up to 6 hours in an 8 hour work day; sit up to 6 hours in an 8 hour work day. This individual could occasionally climb, bend, balance, stoop, kneel, crouch, crawl. This individual could only occasionally handle bilaterally. This individual could, should only be occasionally exposed to extreme heat or humidity. This individual would be limited to tasks that could be learned in 30 days or less involving no more than simple work related decisions with few work place changes. This individual should have only occasional interaction with the public and coworkers and this individual should work in an

environment free of fast paced production requirements. Now, this individual has the same vocational profile as [Meyerhoff]. So, I am not going to ask you whether she can perform her past work, because she has none. Are there light, unskilled jobs in the national economy that could be performed by an individual with these limitations?

(R. 59) The VE stated the hypothetical individual could perform work at the light, unskilled level. He gave examples of lot attendant, mail clerk or sorter in private industry (as opposed to a governmental position), and coin machine collector. (R. 59-60)

The ALJ next asked the VE to consider the same hypothetical individual, but “limited exertionally to no more than sedentary work, where this individual could lift and carry no more than 10 pounds at a time, less than 10 pounds frequently, up to 10 pounds occasionally; [and] standing and walking would be limited to 2 hours in an 8 hour work day[.]” (R. 60) The VE indicated there were no sedentary, unskilled jobs the individual could perform that exist in any significant numbers in the national economy. (*Id.*)

The ALJ next asked the VE to return to the first hypothetical individual who can perform work at the light level, but to add the limitation of the necessity to be absent from work three or more times each month. The VE indicated such a person could not perform work on a competitive and sustained basis. (R. 60-61) Similarly, absenteeism of three times per week would eliminate competitive employment. (R. 61-62)

Meyerhoff’s attorney asked the VE to consider the effect on all of the ALJ’s three hypothetical individuals if the person “would have to change positions at least every 15 minutes, either standing or sitting and then maintaining the altered position for 10 to 15 minutes or more.” (R. 62) The VE stated such an individual would be unable to work. He explained that “unskilled work is specifically structured so that a worker does not have the option of changing positions, more or less, at will. That’s . . . just a general assumption and in fact it’s noted in the . . . regulations[.]” (*Id.*) The VE stated that changing positions “from standing to walking to sitting every 15 minutes or so would

affect an individual's pace to where competitive employment can not be performed.” (*Id.*) He further stated that if an individual could “lift less than 10 pounds and rarely lift 10 pounds,” the individual would not be able to perform even sedentary work. (*Id.*)

4. *The ALJ's decision*

The ALJ found that Meyerhoff had not engaged in substantial gainful activity since August 17, 2006, the date of her application. She found Meyerhoff has severe impairments consisting of degenerative disk disease at C5-6 and L2-3, fibromyalgia, osteoporosis, depression, anxiety, carpal tunnel syndrome, rotator cuff tear on the left, and headaches. However, she further found that Meyerhoff's impairments, either singly or in combination, do not meet the requirements of the Listings. (R. 13)

The ALJ determined that Meyerhoff has the following residual functional capacity (“RFC”):

[She] has the residual functional capacity to perform light work as defined in 20 CFR 416.967(b). She can lift and carry up to 20 pounds occasionally and up to ten pounds frequently. She can stand and walk a total of six hours out of an eight hour workday. She can sit six hours out of an eight hour workday. She can occasionally climb, bend, balance, stoop, kneel, crouch and crawl. She is limited in her ability to repetitively handle, and can only occasionally handle, bilaterally. She can tolerate only occasional exposure to extremes of heat and humidity. She requires tasks that can be learned in 30 days or less, involving no more than simple work related decisions with few work place changes. She can tolerate only occasional interaction with the public and co-workers. She requires an environment free of fast paced production requirements.

(R. 15)

The ALJ found Meyerhoff's subjective complaints regarding the intensity, persistence, and limiting effects of her symptoms were not credible to the extent they differed from the RFC as found by the ALJ. In so finding, the ALJ noted several

inconsistencies between Meyerhoff's subjective complaints and the medical evidence of record, and she concluded "the objective findings in this case fail to provide strong support for the allegations of symptoms which produce limitations on the claimant's ability to perform basic work activities." (R. 17; *see* R. 16-17)

The ALJ gave considerable weight to Dr. Dankle's opinions derived from his consultative examination of Meyerhoff. She noted, "Dr. Dankle indicated the claimant was capable of lifting 10 to 20 pounds on occasion. He stated that she could stand, move about, walk and sit at her tolerance with a change in positions. She should avoid stooping, climbing, kneeling and crawling. She had no limitations with handling objects, seeing, hearing, speaking, traveling or with regards to a work environment." (R. 18) The ALJ found Dr. Dankle's opinions to be consistent with the medical evidence of record. (*Id.*)

The ALJ gave minimal weight to the opinions of psychologist Carroll D. Roland, Ph.D., noting Dr. Roland "only saw the claimant on one occasion[,] did not perform a records review and seemed to rely only on the subjective complaints of the claimant in rendering her opinion." (*Id.*) The ALJ noted Dr. Lovick had indicated Meyerhoff's restrictions would be "guided by pain and tolerance," and he gave no formal restrictions on Meyerhoff's ability to lift, carry, stand, stoop, walk, kneel, handle, hear, see, speak, travel, and work environment. (*Id.*) The ALJ further noted that Dr. Trimble, who treated Meyerhoff off and on from 2004 until 2008, had imposed minimal restrictions, indicating Meyerhoff should not lift more than twenty pounds; "should not perform repetitive work with her hands, other than typing or computer work"; and should not work more than eight hours a day, forty hours a week. (*Id.*) The ALJ gave considerable weight to Dr. Trimble's opinions. (*Id.*)

The ALJ gave "lesser weight" to the opinions of Dr. Eshelman-Peters, noting the doctor's "extreme recommendations are inconsistent with the entire medical record, including the opinion of the claimant's treating physician Dr. Trimble and the claimant's

own self report at Exhibit B5E [a Function Report completed by Meyerhoff on September 8, 2006].” (R. 19; *see* Ex. B5E, R. 287-95)

The ALJ found Meyerhoff had no past relevant work, a limited education, and was “approaching advanced age” as of the date her application was filed. (R. 19) Considering Meyerhoff’s age, education, work experience, and RFC, the ALJ concluded Meyerhoff is able to work at less than the full range of unskilled, light jobs, but she nevertheless has the capacity to perform jobs that exist in significant numbers in the national economy such as lot attendant, mail clerk, and coin machine collector. (R. 20) She therefore concluded that Meyerhoff is not disabled. (R. 21)

III. DISABILITY DETERMINATIONS, THE BURDEN OF PROOF, AND THE SUBSTANTIAL EVIDENCE STANDARD

A. Disability Determinations and the Burden of Proof

Section 423(d) of the Social Security Act defines a disability 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 which 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); 20 C.F.R. § 404.1505. 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. § 432(d)(2)(A).

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); *Hillier v. Social Security Admin.*, 486 F.3d 359, 363 (8th Cir. 2007); *Goff v. Barnhart*, 421 F.3d 785 (8th Cir. 2005); *Dixon v. Barnhart*, 353 F.3d 602, 605

(8th Cir. 2003). 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(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*, 353 F.3d at 605; *accord Lewis v. Barnhart*, 353 F.3d 642, 645 (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 708 (citing *Bowen v. Yuckert*, 482 U.S. 137, 107 S. Ct. 2287, 98 L. Ed. 2d 119 (1987); *id.* at 158, 107 S. Ct. at 2300 (O’Connor, J., concurring); 20 C.F.R. § 404.1521(a)).

The United States Supreme Court has explained:

The ability to do basic work activities is defined as “the abilities and aptitudes necessary to do most jobs.” . . . Such abilities and aptitudes include “[p]hysical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling”; “[c]apacities for seeing, hearing, and speaking”; “[u]nderstanding, carrying out and remembering simple instructions”; “[u]se of judgment”; “[r]esponding appropriately to supervision, co-workers, and usual work situations”; and “[d]ealing with changes in a routine work setting.”

Bowen v. Yuckert, 482 U.S. 137, 140-42, 107 S. Ct. 2287, 2291, 96 L. Ed. 2d 119 (1987) (citing 20 C.F.R. §§ 404.1521(b), 416.921(b)). *See Page v. Astrue*, 484 F.3d 1040, 1043 (8th Cir. 2007) (“‘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.’ *Caviness v. Massanari*, 250 F.3d 603, 605 (8th

Cir. 2001), *citing Nguyen v. Chater*, 75 F.3d 429, 430-31 (8th Cir. 1996).”); *accord Kirby, supra*.

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, or work experience. 20 C.F.R. § 404.1520; *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 residual functional capacity (“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(4)(iv); 404.1545(4); *see Lewis*, 353 F.3d at 645-46 (“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.”) (citing *Bradshaw v. Heckler*, 810 F.2d 786, 790 (8th Cir. 1987); 20 C.F.R. § 404.1520(e) (1986)); *Dixon, supra*. 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(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. 20 C.F.R. § 404.1520(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], age, education, and work experience.” Clarification of Rules Involving Residual Functional Capacity Assessments, etc., 68 Fed. Reg. 51,153, 51,155 (Aug. 26, 2003). 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. *Id.*; 20 C.F.R. § 404.1520(4)(v); *Dixon, supra*; *Pearsall v. Massanari*, 274 F.3d 1211, 1217 (8th Cir. 2001) (“[I]f the claimant cannot perform the past work, the burden then shifts to the Commissioner to prove that there are other jobs in the national economy that the claimant can perform.”) (citing *Cox v. Apfel*, 160 F.3d 1203, 1206 (8th Cir. 1998)); *Nevland v. Apfel*, 204 F.3d 853, 857 (8th Cir. 2000). 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 the claimant is disabled. 20 C.F.R. § 404.1520(r)(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. *See Goff*, 421 F.3d at 790 (citing *Stormo v. Barnhart*, 377 F.3d 801, 806 (8th Cir. 2004)).

The court reviews an ALJ’s decision to determine whether the ALJ applied the correct legal standards, and whether the factual findings are supported by substantial evidence on the record as a whole. *Page*, 484 F.3d at 1042 (citing *Haggard v. Apfel*, 175 F.3d 591, 594 (8th Cir. 1999), in turn citing *Clark v. Apfel*, 141 F.3d 1253, 1255 (8th Cir. 1998)); *Hensley v. Barnhart*, 352 F.3d 353, 355 (8th Cir. 2003). This review is deferential; the court “must affirm the Commissioner’s decision if it is supported by substantial evidence on the record as a whole.” *Pelkey v. Barnhart*, 433 F.3d 575, 578 (8th Cir. 2006); 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. . . .”). Under this

standard, “[s]ubstantial evidence is less than a preponderance but is enough that a reasonable mind would find it adequate to support the Commissioner’s conclusion.” *Krogmeier v. Barnhart*, 294 F.3d 1019, 1022 (8th Cir. 2002) (citing *Prosch v. Apfel*, 201 F.3d 1010, 1012 (8th Cir. 2000)); accord *Page*, 484 F.3d at 1042 (“Substantial evidence is relevant evidence which a reasonable mind would accept as adequate to support the Commissioner’s conclusion.”) (quoting *Haggard*, 175 F.3d at 594); *Pelkey*, *supra* (quoting *Goff*, 421 F.3d at 789).

Moreover, substantial evidence “on the record as a whole” requires consideration of the record in its entirety, taking into account both “evidence that detracts from the Commissioner’s decision as well as evidence that supports it.” *Krogmeier*, 294 F.3d at 1022. 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. 1997)).

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. Secretary of Health & Human Serv.*, 879 F.2d 441, 444 (8th Cir. 1989) (citing *Steadman v. S.E.C.*, 450 U.S. 91, 99, 101 S. Ct. 999, 1006, 67 L. Ed. 2d 69 (1981)). 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 agency’s findings, [the court] must affirm the [Commissioner’s] decision.” *Id.* (quoting *Robinson v. Sullivan*, 956 F.2d 836, 838 (8th Cir. 1992), and citing *Cruse v. Bowen*, 867 F.2d 1183, 1184 (8th Cir. 1989)); accord *Baldwin*, 349 F.3d at 555; *Young v. Apfel*, 221

F.3d 1065, 1068 (8th Cir. 2000). This is true even in cases where the court “might have weighed the evidence differently.” *Culbertson v. Shalala*, 30 F.3d 934, 939 (8th Cir. 1994) (citing *Browning v. Sullivan*, 958 F.2d 817, 822 (8th Cir. 1992)); *accord Krogmeier*, 294 F.3d at 1022 (citing *Woolf v. Shalala*, 3 F.3d 1210, 1213 (8th Cir. 1993)). The court may not reverse the Commissioner’s decision “merely because substantial evidence would have supported an opposite decision.” *Goff*, 421 F.3d at 789 (“[A]n administrative decision is not subject to reversal simply because some evidence may support the opposite conclusion.”); *accord Page*, 484 F.3d at 1042-43 (citing *Kelley v. Barnhart*, 372 F.3d 958, 961 (8th Cir. 2004); *Travis v. Astrue*, 477 F.3d 1037, 1040 (8th Cir. 2007); *Cox v. Barnhart*, 471 F.3d 902, 906 (8th Cir. 2006)).

On the issue of an ALJ’s determination that a claimant’s subjective complaints lack credibility, the Sixth and Seventh Circuits have held an ALJ’s credibility determinations are entitled to considerable weight. *See, e.g., Young v. Secretary of H.H.S.*, 957 F.2d 386, 392 (7th Cir. 1992) (citing *Cheshier v. Bowen*, 831 F.2d 687, 690 (7th Cir. 1987)); *Gooch v. Secretary of H.H.S.*, 833 F.2d 589, 592 (6th Cir. 1987); *Hardaway v. Secretary of H.H.S.*, 823 F.2d 922, 928 (6th Cir. 1987). Nonetheless, in the Eighth Circuit, an ALJ may not discredit a claimant’s subjective allegations of pain, discomfort, or other disabling limitations simply because there is a lack of objective evidence; instead, the ALJ may only discredit subjective complaints if they are inconsistent with the record as a whole. *See Hinchey v. Shalala*, 29 F.3d 428, 432 (8th Cir. 1994); *see also Bishop v. Sullivan*, 900 F.2d 1259, 1262 (8th Cir. 1990) (citing *Polaski v. Heckler*, 739 F.2d 1320, 1322 (8th Cir. 1984)). As the court explained in *Polaski v. Heckler*:

The adjudicator must give full consideration to all of the evidence presented relating to subjective complaints, including the claimant’s prior work record, and observations by third parties and treating and examining physicians relating to such matters as:

- 1) the claimant’s daily activities;

- 2) the duration, frequency and intensity of the pain;
- 3) precipitating and aggravating factors;
- 4) dosage, effectiveness and side effects of medication;
- 5) functional restrictions.

739 F.2d 1320, 1322 (8th Cir. 1984); accord *Ramirez v. Barnhart*, 292 F.3d 576, 580-81 (8th Cir. 2002). The court must “defer to the ALJ’s determinations regarding the credibility of testimony, so long as they are supported by good reasons and substantial evidence.” *Guilliams v. Barnhart*, 393 F.3d 798, 801 (8th Cir. 2005).

DISCUSSION

Meyerhoff argues the record does not contain substantial evidence to support the ALJ’s RFC determination. (Doc. No. 10) She argues that in determining her RFC, the ALJ erred in relying on a form Meyerhoff completed “way back in 2006,” when she explained at her 2009 ALJ she now needs her sons’ assistance to accomplish many of the activities she stated she could perform in 2006. Even on the form she completed in 2006, she indicated her sons performed some of the household activities, and she babysat her grandchildren from 10:00 p.m. until 7:00 a.m., when they were sleeping. (*Id.*) She further argues the ALJ erred in the weight she assigned to the opinions of the medical sources, and the ALJ improperly discounted Meyerhoff’s subjective pain complaints. (*Id.*, pp. 8-9)

Meyerhoff further argues the ALJ posed an improper hypothetical question to the VE that did not mirror Meyerhoff’s limitations. In particular, she notes “the ALJ failed to include the nearly unanimously agreed upon limitations of needing periodic breaks, and of not being able to be on her feet all day, in spite of overwhelming evidence of them, and failed to explain a valid reason for that failure.” (*Id.*, p. 14) She notes that when a

hypothetical question fails to include all of a claimant's limitations, the VE's response cannot constitute substantial evidence to support a finding of no disability. (*Id.*, pp. 14-15)

Finally, Meyerhoff argues the record contains "overwhelming evidence" that she is unable to perform any type of full-time work. She therefore asks the court to find she is disabled, and remand for payment of benefits. (*Id.*, p. 15)

The Commissioner disagrees on all points. The Commissioner notes Meyerhoff repeatedly refused treatment for her fibromyalgia and her mental health issues, and the medical evidence of record fails to support Meyerhoff's claims regarding the extent to which her symptoms limit her activities and her ability to work. (Doc. No. 11, pp. 12-13) The Commissioner argues Meyerhoff's refusal of treatment is particularly significant because "a diagnosis of fibromyalgia is based largely on subjective complaints[.]" (*Id.*, p. 14) The Commissioner also points out that while an ALJ may not discount a claimant's subjective complaints solely on the basis of a lack of objective medical evidence of record that supports those complaints, the ALJ may "consider the objective medical evidence as one important factor in the credibility analysis." (*Id.*, p. 17, citations omitted) The Commissioner further argues the ALJ properly weighed the medical evidence of record. (*Id.*, pp. 18-22)

Regarding the ALJ's RFC determination, the Commissioner argues the ALJ considered the record as a whole, including the medical evidence, testimony, and claimant's own description of her limitations. The Commissioner asserts, "The ALJ had no reason to include a need for periodic breaks in the RFC based on the opinions of physicians that [Meyerhoff] would need to 'change positions' or need 'periodic breaks' because . . . physicians are not familiar with the requirements of particular jobs or the normal amount of breaks provided by employers. In addition, physical examination findings did not support such a limitation." (*Id.*, pp. 23-24, citations omitted)

In her reply, Meyerhoff argues the Commissioner is improperly attempting to assert new grounds to support the ALJ's decision that were not given by the ALJ. (Doc. No. 12) For example, Meyerhoff notes the Commissioner repeatedly referred to the fact that Meyerhoff declined treatment for her fibromyalgia as grounds for the ALJ's credibility finding. She argues the ALJ never mentioned this as a reason for discounting Meyerhoff's subjective complaints, "most likely because the ALJ understands fibromyalgia and people who suffer [from] fibromyalgia." (*Id.*, pp. 1-2) Meyerhoff also argues the ALJ's failure to give more weight to Dr. Roland's opinions was not "harmless," as argued by the Commissioner. (*Id.*, p. 3)

The record contains substantial evidence that Meyerhoff would be unable to sustain full-time employment on a sustained basis. The ALJ indicated she was giving considerable weight to the opinions of Dr. Dankle, but then she failed to credit Dr. Dankle's opinion that Meyerhoff "likely will need to change positions on a regular basis," and would only be able to "stand, move about, walk, and sit *at her tolerance*." (R. 830, emphasis added) The ALJ specifically found that Dr. Dankle's opinions were consistent with the medical evidence of record. (*See* R. 18)

Dr. Trimble, Meyerhoff's long-term treating physician, also noted Meyerhoff "should be allowed periodic breaks." (R. 965) And although Dr. Lovick did not list any formal restrictions in Meyerhoff's work-related abilities, the ALJ noted that Dr. Lovick indicated Meyerhoff's restrictions would be "guided by pain and tolerance." (*See* R. 18)

When the VE was asked by Meyerhoff's attorney whether an individual who has to change positions frequently would be able to work, he responded in the negative, noting "unskilled work is specifically structured so that a worker does not have the option of changing positions, more or less, at will. That's . . . just a general assumption and in fact it's noted in the . . . regulations[.]" (R. 62)

The court finds the ALJ erred in failing to include this limitation in the hypothetical question to the VE, and in omitting this limitation from the ALJ's RFC determination. The record does not contain substantial evidence to supports the ALJ's RFC determination, or her finding that Meyerhoff is able to sustain full-time, competitive employment. Conversely, the record "overwhelmingly supports" an immediate finding of disability. *See Buckner v. Apfel*, 213 F.3d 1006, 1011 (8th Cir. 2000).

A remaining issue to be determined is the applicable time period of Meyerhoff's disability. In her brief, Meyerhoff argues that because each of her successive applications was filed within twelve months of the previous denial, "the Commissioner should automatically reopen the two prior applications." (Doc. No. 10, p. 1, citing 20 C.F.R. §§ 404.988(a), 416.1488(a)) The Commissioner disagrees, arguing:

Generally, a claimant loses the right to further review of a determination if the claimant does not request further review within the stated time period. *See* 20 C.F.R. § 416.1487. While a determination may be reopened "within 12 months of the date of the notice of the initial determination, for any reason," 20 C.F.R. § 416.1488(a), the ALJ in the instant case did not reopen the prior final determinations.

(Doc. No. 11, p. 2, n.1; emphasis in original)

The ALJ did not make *any* determination in her decision regarding whether Meyerhoff's prior applications should be reopened. Neither Meyerhoff nor the ALJ raised the issue at the hearing. It is clear from the ALJ's decision that she considered only whether Meyerhoff has "been under a disability . . . since August 17, 2006, the date [the most recent] application was filed." (R. 11) It is unclear whether the ALJ had before her the records relating to Meyerhoff's prior applications, but even if she did, her opinion was silent on the reopening issue. As such, the court finds no final decision has been made on the reopening issue, and therefore the issue is not subject to appeal. *See Sylcord v. Chater*, 921 F. Supp. 631, 638-40 (N.D. Iowa 1996) (Bennett, J.). Therefore, remand is

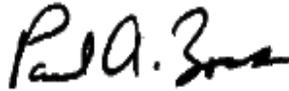
appropriate for consideration of the period when Meyerhoff's disability commenced, and whether to reopen her prior applications.

IV. CONCLUSION

For the reasons discussed above, **IT IS RESPECTFULLY RECOMMENDED**, unless any party files objections* to the Report and Recommendation in accordance with 28 U.S.C. § 636 (b)(1) and Fed. R. Civ. P. 72(b), within 14 days of the service of a copy of this Report and Recommendation, that the Commissioner's decision be reversed, and this case be remanded for a determination of when Meyerhoff's disability began, for purposes of calculation and immediate award of benefits.

IT IS SO ORDERED.

DATED this 26th day of July, 2010.



PAUL A. ZOSS
CHIEF MAGISTRATE JUDGE
UNITED STATES DISTRICT COURT

*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.