

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

JACQUELINE K. MOJZIS,

Plaintiff,

vs.

MICHAEL J. ASTRUE,

Commissioner of Social Security,

Defendant.

No. C07-0072

RULING ON JUDICIAL REVIEW

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I. INTRODUCTION

This matter comes before the Court on the Complaint (docket number 3) filed by Plaintiff Jacqueline K. Mojzis on August 1, 2007, requesting judicial review of the Social Security Commissioner's decision to deny her application for Title XVI supplemental security income ("SSI") benefits. Mojzis asks the Court to reverse the decision of the Social Security Commissioner ("Commissioner") and order the Commissioner to provide SSI benefits. In the alternative, Mojzis requests the Court to remand this matter for further proceedings.

II. PRIOR PROCEEDINGS

Mojzis applied for SSI benefits on January 20, 2004. In her application, Mojzis alleged an inability to work since March 1, 2003, due to back pain, fibromyalgia, and depression. Mojzis' application was denied on March 25, 2004. On August 25, 2004, her application was denied on reconsideration. On November 1, 2004, Mojzis requested an administrative hearing before an Administrative Law Judge ("ALJ"). On August 14, 2006, Mojzis appeared with counsel, via video conference, before ALJ George Gaffaney for an evidentiary hearing. Mojzis and vocational expert Roger F. Marquardt testified at the hearing. In a decision dated November 21, 2006, the ALJ denied Mojzis' claim. The ALJ determined that Mojzis was not disabled and was not entitled to SSI benefits because she was functionally capable of performing work that exists in significant numbers in the national economy. Mojzis appealed the ALJ's decision. On May 30, 2007, the Appeals Council denied Mojzis' request for review. Consequently, the ALJ's November 21, 2006 decision was adopted as the Commissioner's final decision.

On August 1, 2007, Mojzis filed this action for judicial review. The Commissioner filed an answer on November 13, 2007. On December 17, 2007, Mojzis filed a brief arguing there is not substantial evidence in the record to support the ALJ's finding that she is not disabled and that there is other work she can perform. On February 15, 2008, the Commissioner filed a responsive brief arguing the ALJ's decision was correct and asking

the Court to affirm the ALJ's decision. Mojzis filed a reply brief on February 26, 2008. On September 26, 2007, both parties consented to proceed before the undersigned in this matter pursuant to the provisions set forth in 28 U.S.C. § 636(c).

III. PRINCIPLES OF REVIEW

Pursuant to 42 U.S.C. § 1383(c)(3), the Commissioner's final determination after an administrative hearing not to award SSI benefits is subject to judicial review to the same extent as provided in 42 U.S.C. § 405(g). 42 U.S.C. § 1383(c)(3). 42 U.S.C. § 405(g) provides the Court with the power to: "[E]nter . . . a judgment affirming, modifying, or reversing the decision of the Commissioner . . . with or without remanding the cause for a rehearing." 42 U.S.C. § 405(g). "The findings of the Commissioner . . . as to any fact, if supported by substantial evidence, shall be conclusive . . ." *Id.*

The Court must consider "whether the ALJ's decision is supported by substantial evidence on the record as a whole." *Vester v. Barnhart*, 416 F.3d 886, 889 (8th Cir. 2005) (citing *Harris v. Barnhart*, 356 F.3d 926, 928 (8th Cir. 2004)). Evidence is "substantial evidence" if a reasonable person would find it adequate to support the ALJ's determination. *Id.* (citing *Sultan v. Barnhart*, 368 F.3d 857, 862 (8th Cir. 2004)). Furthermore, "[s]ubstantial evidence is 'something less than the weight of the evidence, and the possibility of drawing two inconsistent conclusions does not prevent an administrative agency's findings from being supported by substantial evidence.'" *Baldwin v. Barnhart*, 349 F.3d 549, 555 (8th Cir. 2003) (quoting *Cruse v. Bowen*, 867 F.2d 1183, 1184 (8th Cir. 1989), in turn quoting *Consolo v. Fed. Mar. Comm'n*, 282 U.S. 607, 620 (1966)).

In determining whether the ALJ's decision meets this standard, the Court considers "all of the evidence that was before the ALJ, but it [does] not re-weigh the evidence." *Vester*, 416 F.3d at 889 (citing *Guilliams v. Barnhart*, 393 F.3d 798, 801 (8th Cir. 2005)). The Court not only considers the evidence which supports the ALJ's decision, but also the evidence that detracts from his or her decision. *Guilliams*, 393 F.3d at 801. "[E]ven if

inconsistent conclusions may be drawn from the evidence, the agency's decision will be upheld if it is supported by substantial evidence on the record as a whole." *Id.* (citing *Chamberlain v. Shalala*, 47 F.3d 1489, 1493 (8th Cir. 1995)).

IV. FACTS

A. Mojzis' Education and Employment Background

Mojzis was born in 1953. She attended high school and finished the eleventh grade. She has not earned a GED. The record contains a detailed earnings report for Mojzis. The earnings report provides that she had sporadic employment between 1990 and 2001. Her highest earnings were \$2136.75 in 1994. The record contains no information for earnings after 2001.

B. Administrative Hearing Testimony

1. Mojzis' Testimony

At the administrative hearing, Mojzis' attorney asked Mojzis questions about her physical health. When asked to describe her neck problems, Mojzis explained that she gets severe headaches and "sometimes it just feels like my head's too heavy for my neck."¹ She also indicated that she suffers from low back pain. According to Mojzis, her back pain makes it difficult for her to "stand very long at one time and I get a lot of numbness in my legs and my legs feel like they're floating a lot."² She testified that she lays on her side to relieve the pressure on her neck and back. Mojzis' attorney also asked Mojzis to describe her limitations with her hands. She testified that she cannot write or lift anything with her right hand. Lastly, Mojzis' attorney asked her discuss her diagnosis of fibromyalgia. According to Mojzis, her fibromyalgia causes her pain throughout her entire body, including constant tightness and achiness in her muscles and bones. She further explained that her fibromyalgia decreases her energy level and makes her feel tired all of

¹ See Administrative Record at 331.

² *Id.* at 332.

the time. Mojzis also testified that she has difficulty sleeping because she is constantly trying to get herself comfortable. She takes hot baths to alleviate the pain.

Mojzis' attorney also asked Mojzis about her mental health. Mojzis testified that she suffered from depression. According to Mojzis, her depression caused a lack of motivation. Specifically, she testified that she was "down but I mean, I wouldn't be you know, with the pain I go through every day. I mean, my life is pretty limited you know. You're not going to be on top of the world when you know, you have to be careful where you go and what you do and so you don't fall down[.] . . ." ³

When asked to describe her typical day, Mojzis responded that she picks up the house everyday. She also indicated that she cooks and does the dishes. She testified, however, that a cleaning lady does the heavy cleaning, such as scrubbing the floors. According to Mojzis, she spends about two hours everyday performing household chores, and the rest of the day she doesn't do "much of anything."

The ALJ also questioned Mojzis. The ALJ asked Mojzis whether she had any trouble with concentration or memory. Mojzis answered that her short-term memory was bad and she had trouble with concentration. She attributed her difficulties with memory and concentration to a lack of good sleep. The ALJ asked her why she lacked good sleep. She responded:

Because I hurt all night long and part of it is part of the depression. I've had trouble sleeping for a long time but I had trouble going to sleep and staying asleep but I take medicine to help me sleep but the fibromyalgia or whatever is hurting me. I have to get up and try to get the cramps out and stuff and so -- and I have to keep repositioning because I'll get -- if I stay in one spot too long I get very sore and then I got to try and lay another way. So, I'm -- you know, I don't get much peaceful sleep.

³ See Administrative Record at 334.

(Administrative Record at 341) When asked whether she had any trouble standing or sitting, Mojzis replied that standing is difficult because her legs get numb and she loses control over them. She also testified that she cannot sit for more than one-half hour before she needs to get up and move around. According to Mojzis, she also has difficulty climbing stairs. When asked whether she had anything else to say, Mojzis replied:

CLMT: Yeah. You know, I really could have been without some of the pain if I'd have taken some of the more potent painkillers that were prescribed me. And because I worked so hard at getting my life straightened out and my sobriety I refused anything that had any narcotic in it because I feel I've come this far and I don't want to get hooked on painkillers in place of the alcohol. And so I go through the pain but it's still better than the way my life was before emotionally but I just would like to be able to see doctors regularly and get regular care so my quality of life can improve. This hurry up and waiting thing you know, when you wait for [(sic)] months for an appointment or three months for an appointment and you're still going through the same thing it's very hard.

ALJ: And the -- and when you talk about see the doctor and get regular treatment and the hold up there is simply the waiting time to get in to see the doctor?

CLMT: That and through the Iowa card there's so much red tape that you -- it has to all be preapproved and you know, so -- it's like with my hand, I waited from February until May to have anything -- you know, find anything out about that and we're still not even sure of that. Well, I'm going to see the neurologist or the neurosurgeon, so -- you know, it's just waiting and it doesn't help my anxiety you know. I just would like to go and get the care that I need.

(Administrative Record at 352-53)

2. Vocational Expert's Testimony

At the hearing, the ALJ provided vocational expert Roger Marquardt with a hypothetical for an individual with the following limitations:

[The individual is able to lift up] to 50 pounds occasionally and 25 [pounds] frequently. Stand and sit six hours each in an eight-hour workday. Occasional ladder and stair climbing. Frequent balance, stoop, kneel, crouch and crawl. Frequent handling with the right hand. Frequent exposure to extremes of cold and to humidity and wetness. No exposure to hazards such as heights or moving parts. Simple, routine tasks with occasional changes in a routine work setting.

(Administrative Record at 349) The vocational expert testified that under such limitations, Mojzis could perform work as an office machine operator (860 positions in Iowa and 85,000 positions in the nation), order clerk (2,000 positions in Iowa and 275,000 positions in the nation), or retail maker/pricer (18,000 positions in Iowa and 1,500,000 positions in the nation). The ALJ provided the vocational expert with a second hypothetical with the same limitations, except that the individual could only lift 20 pounds occasionally and 10 pounds frequently. The vocational expert testified that the individual could perform the jobs described under the first hypothetical. The ALJ provided a third hypothetical which had the same limitations as the first hypothetical, except that the individual could only lift 10 pounds occasionally and 5 pounds frequently. The vocational expert testified that under such limitations, the individual would be limited to sedentary work with light strength demands.

Mojzis' attorney also questioned the vocational expert. Mojzis' attorney asked the vocational expert the following questions:

ATTY: . . . If the hypothetical person due to mental and/or pain symptoms would have to work at a slow pace up to one-third of the workday would they be employable?

VE: Not in the competitive job market, no.

ATTY: And due to pain and/or psychological symptoms if they needed to take additional work breaks

more than normal allowed by employer to say two half-hour work breaks where they needed to lie down, elevate legs to get some pain relief would that be acceptable to an employer?

VE: It would not.

ATTY: So, would that eliminate the jobs you indicated were available in one and two?

VE: Yes.

ATTY: And all other jobs?

VE: And all other full-time jobs, yes.

(Administrative Record at 351-52)

C. Mojzis' Medical History

On February 22, 2003, Mojzis presented at the Columbus Community Hospital Emergency Department in Columbus, Wisconsin, complaining of back pain and right leg weakness. She reported that her pain and weakness started approximately two weeks prior to her visit to the emergency department. Dr. B.A. Kraus, M.D., noted that Mojzis' pain started in the right lower lumbar region of her back and radiated down the posterior leg to the distal right lower leg. Dr. Kraus also noted that she had a history of depression, thyroid problems, asthma, and an eight-year history of seizures. Upon examination, Dr. Kraus noted that Mojzis appeared quite uncomfortable and preferred lying on her side. Dr. Kraus found some tenderness in the right lumbosacral area and pain on the right side of her back when she did leg raises while lying in a supine position. Dr. Kraus diagnosed her with right back and leg pain, probably right sciatica, asthma, seizure disorder, and depression. Dr. Kraus admitted Mojzis to the hospital for initial pain management strategies and physical therapy assessment. While in the hospital, Mojzis showed gradual improvement and was transitioned to Oxycodone with Acetaminophen for pain management. Mojzis was discharged from the hospital on February 26, 2003. She was advised to continue her pre-hospital medications and prescribed Oxycodone/Acetaminophen for treatment.

On January 25, 2004, Mojzis was admitted to Beaver Dam Community Hospital in Beaver Dam, Wisconsin for “acute intoxication and falling down.” Dr. B.A. Allen, M.D., noted that Mojzis’ past medical history included: (1) Chronic alcoholism, (2) chronic low back pain and chronic neck pain for more than one year, (3) seizure disorder and hypothyroidism, and (4) depression. Dr. Allen described Mojzis’ hospital course as follows:

[Mojzis] was detoxed per alcohol withdrawal protocol. She did not have any significant problems in this regard. . . . Her biggest concern has been her low back pain which has been a problem for over a year. . . . Her tobacco abuse is handled with the nicotine patch during this hospitalization. Back pain handled with Vioxx and Morphine p.r.n.

(Administrative Record at 152) Mojzis was discharged on January 26, 2004, and prescribed Vicodin, Naproxen, Synthroid, Dilantin, and Wellbutrin as treatment.

On February 3, 2004, Mojzis underwent an x-ray of her lumbar spine. Dr. M. David Yoseloff, M.D., found no evidence of pedicular destruction or acute compression fracture. Dr. Yoseloff noted a spina bifida occulta of S1. Dr. Yoseloff found mild relative retrolisthesis of L5 in relationship to L4 and questionably to S1 and of L3 in relationship to L4. Dr. Yoseloff also found some minimal calcification lying posterior to the disc space at the L4-5 level. Lastly, Dr. Yoseloff determined that there was “very minimal” disc space narrowing at the T11-12, T12-L1, L1-2, L2-3, and L3-4 levels. Dr. Yoseloff diagnosed Mojzis with mild degenerative changes in he lumbar spine.

On February 24, 2004, Mojzis met with Dr. Joseph D. Meyer, M.D., complaining of chronic back and neck pain. Dr. Meyer noted that her pain had gotten worse because she was out of her prescription medications. Dr. Meyer refilled some of Mojzis’ prescriptions and recommended that she establish a primary care physician to manage her chronic back and neck pain, thyroid disorder, seizure disorder, and depression. Dr. Meyer noted that he did not think Mojzis would be compliant with his recommendation.

On March 5, 2004, Mojzis visited Dr. Sankar Bandy, M.D., for evaluation of her seizure problem. Dr. Bandy provided a detailed description of Mojzis' seizure disorder:

[Mojzis] has been having seizures for the last ten years. According to [Mojzis], she had no seizures during her infancy or childhood or earlier life. She had a lot of head injuries due to domestic abuse by her ex-husband[.] . . . She says that she had "blood in her brain" and after several years she started having the seizure problem. . . . The first four or five years she took Depakote and then because of side effects she was switched to Dilantin. She stopped taking the medicines and she had four generalized tonic-clonic seizures one month ago. In general, her frequency is one or two generalized tonic-clonic seizures a month , even on medicine[.] . . . She gets an aura consisting of a head pressure and a funny feeling or taste inside the mouth followed by loss of consciousness and generalized tonic-clonic seizure for several minutes with urinary incontinence but no tongue biting and she would be confused after the seizure.

(Administrative Record at 232) Dr. Bandy diagnosed her with late onset seizure disorder or epilepsy. Dr. Bandy prescribed Mojzis Dilantin for treatment. Dr. Bandy emphasized that she needed to be compliant with the prescribed drugs. Dr. Bandy also warned Mojzis to be careful of potentially hazardous conditions such as "holding sharp objects, heavy objects, swimming alone, cooking alone, standing at the waterfront, going up high altitude place, or up on a ladder, bar, or stool, [or] leaning over a tall building."⁴

On April 26, 2004, police took Mojzis to Gundersen Lutheran Medical Center in La Crosse, Wisconsin, because the police found her lying on a bench with a decreased level of consciousness. The emergency room doctors determined that Mojzis was intoxicated. Her blood alcohol content was .385. She was admitted to the hospital for inpatient treatment. While in the hospital, Mojzis spoke with Dr. David W. Metzler, M.D. She informed Dr. Metzler that she had been drinking for about one month because she was depressed. In addition to the alcohol, Mojzis also consumed an unknown quantity

⁴ See Administrative Record at 231.

of pills in an attempt to kill herself. Dr. Metzler noted “[s]he does not think that she really wanted to kill herself but that is what the thought was.”⁵ Dr. Metzler found Mojzis to be sad and depressed. Dr. Metzler diagnosed her with alcohol dependence and depressive disorder. After undergoing detoxification, Mojzis was discharged from the hospital on May 6, 2004. She was instructed to attend AA meetings and not drink alcohol.

On June 8, 2004, Mojzis had MRI examinations on her cervical spine and lumbar spine. The MRI of her cervical spine showed degenerative disc disease at the C4, C5, and C6 levels. The MRI also showed left-sided disc extrusion at the C4 level, moderate central canal stenosis at the C5 level, and mild to moderate central canal stenosis at the C6 level. The MRI of her lumbar spine showed moderate central stenosis at the level of the L4-5 interspace, small left-sided disc extrusion at the L2 level, and facet arthropathy at the L5 level.

On July 23, 2004, Mojzis revisited Dr. Bandy for further evaluation of her seizure disorder and low back pain. Dr. Bandy noted:

[Mojzis had n]o recurrence of seizure disorder. . . . Also, she has been complaining of low back pain for a long time. We have done MRI of the cervical spine showing degenerative changes and moderate C5 stenosis, but clinically I think it is silent. No cord compression or compression of neurological element. MRI of the lumbar spine with moderate L4-5 stenosis which I also think clinically [is] not causing much problem. Her EMG of the right upper extremity and right lower extremity were also normal. She has an unremarkable neurological examination.

(Administrative Record at 221) Dr. Bandy determined that Mojzis was not a surgical candidate and her pain could be managed conservatively. Dr. Bandy concluded that her pain “is pain that she can live with.”⁶

⁵ *Id.* at 192.

⁶ *See* Administrative Record at 222.

On August 25, 2004, a doctor,⁷ reviewed Mojzis' medical records for Disability Determination Services ("DDS") and provided DDS with a residual functional capacity ("RFC") assessment. The doctor determined that Mojzis could: (1) Occasionally lift and/or carry 50 pounds, (2) frequently lift and/or carry 25 pounds, (3) stand and/or walk with normal breaks for a total of about six hours in an eight-hour workday, (4) sit with normal breaks for a total of about six hours in an eight-hour workday, (5) push and/or pull without limitations. The doctor also determined that Mojzis could occasionally climb, and frequently balance, stoop, kneel, crouch, and crawl. The doctor found no manipulative, visual, communicative, or environmental limitations, except that Mojzis should avoid hazards such as machinery and heights.

On August 27, 2004, Dr. Keith E. Bauer, Ph.D., reviewed Mojzis' medical records and provided DDS with mental RFC and Psychiatric Review Technique assessments for Mojzis. On the Psychiatric Review Technique assessment, Dr. Bauer diagnosed Mojzis with depressive disorder and bipolar disorder. Dr. Bauer determined that Mojzis had the following limitations: Mild restriction of activities of daily living, moderate difficulties in maintaining social functioning, and moderate difficulties in maintaining concentration, persistence, or pace. On the mental RFC assessment, Dr. Bauer determined that Mojzis was moderately limited in her ability to: Understand and remember detailed instructions; carry out detailed instructions; maintain attention and concentration for extended periods; perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances; complete a normal workday and workweek without interruptions from psychologically based symptoms and perform at a consistent pace without an unreasonable number and length of rest periods; accept instructions and respond

⁷ The signature of the doctor who provided the residual functional capacity assessment for Mojzis is illegible and therefore unknown to the Court. *See* Administrative Record at 248.

appropriately to criticism from supervisors; and respond appropriately to changes in the work setting.

On November 30, 2005, Mojzis was evaluated for depression by Ellen Natvig (“Natvig”), a physician’s assistant at the Abbe Center for Community Mental Health (“Abbe Center”) in Cedar Rapids, Iowa. Natvig noted that Mojzis was hospitalized at Mercy Medical Center in Cedar Rapids, Iowa, on November 8, 2005 for suicidal thoughts. Natvig also reviewed Mojzis’ history of depression and depressive symptoms:

[Mojzis] states she has had problems with depression dating back to around age 20. She does believe she had depression as a child as well although was not officially diagnosed with anything. [Mojzis] reports feeling ‘miserable’ and states she ‘just exists.’ She states that her mood is never just right -- its always either high or low. . . . She stated in the last month her mood has been low pretty much everyday. She also reports problems with sleep. She states that she falls asleep easily but wakes up frequently throughout the night. . . . She reports increased daytime fatigue. . . . [Mojzis] reports difficulty with concentration. She states she usually reads quite a bit but has been unable to read and concentrate on reading materials in the last several months. . . . She reports decreased energy which has been going on for some time. [Mojzis] states she is not currently suicidal and ‘doesn’t want to give up. . . .’ She also reports problems with anxiety which has been going on for the last 6 months. . . . [Mojzis] also reports increased irritability. She also reports problems with social anxiety and states starting in July 2005, she did not want to be around people very much and would avoid interactions with others. [Mojzis] also reports a past history of some panic attacks that started 2 years ago when she went through menopause. She states that she has them every so often and has short periods of shortness of breath, chest pain, and nausea. She states sometimes she will wake up in the middle of the night and have difficulty catching her breath. . . . [Mojzis] reports a past history of moodswings and unstable relationships. She reports she has feelings of abandonment. She also reports feeling empty and having no identity.

(Administrative Record at 291-92) Natvig diagnosed Mojzis with major depressive disorder, recurrent and anxiety disorder. Natvig referred Mojzis to an Abbe Center counselor for treatment.

On March 2, 2006, Mojzis met with Karen Penick, LISW (Licensed Independent Social Worker) (“Penick”) at the Abbe Center. Penick found Mojzis’ psychomotor activity to be mildly decreased and intellectual functioning to be in the average or slightly below average range. Penick noted that Mojzis has passive death thoughts “because she feels so badly she thinks she would be better off not being here.”⁸ Penick further noted, however, that she denied any intent or plan to harm herself. Penick diagnosed Mojzis with major depressive disorder, anxiety disorder, and borderline personality disorder traits. Penick recommended that Mojzis continue medication management with Natvig and continue individual therapy as treatment.

On May 22, 2006, Mojzis was evaluated by Dr. Rebecca Tuetken, M.D., for diffuse musculoskeletal pain and hand and leg numbness. Dr. Tuetken noted that Mojzis had a long history of diffuse musculoskeletal pain and had been diagnosed with fibromyalgia. Dr. Tuetken also noted that Mojzis had been increasingly bothered by hand numbness which affected all of her fingers and caused difficulty with grasping. Mojzis further informed Dr. Tuetken that her legs become numb if she stands or walks for more than 5 minutes at a time. Upon examination, Dr. Tuetken found that Mojzis’ hand closure was somewhat limited and her grip strength was reduced bilaterally. Dr. Tuetken also found “marked tenderness over the right thumb extensors and abductors and Finkelstein’s sign for De Quervain’s tenosynovitis was very positive, right more than left.”⁹ Dr. Tuetken also performed a radiograph examination and found spondyloisthesis at C3-C4 and disc narrowing at C5-C6 and C6-C7. Dr. Tuetken diagnosed Mojzis with: (1) Long-

⁸ See Administrative Record at 289.

⁹ See Administrative Record at 275.

standing fibromyalgia, (2) chronic neck and back pain with abnormal spinal curvature, cervical spondylolisthesis, disc narrowing, and degenerative joint disease, (3) bilateral hand numbness, (4) chronic low back pain,¹⁰ (5) polyuria and polydipsia, (6) hypothyroidism, and (7) severe vitamin D deficiency. Dr. Tuetken recommended that Mojzis see an occupational therapist and exercise regularly at treatment. Dr. Tuetken also prescribed ergocalciferol to help her vitamin D deficiency. Lastly, Dr. Tuetken requested an MRI of Mojzis' C-spine to rule out cervical radiculopathy.

On June 21, 2006, Mojzis met with Natvig for medication management. Mojzis informed Natvig that she was depressed and had recently taken a handful of Trazodone in a suicide attempt. Mojzis further informed Natvig that she was "'scared' of harming herself [and] . . . [felt] like she want[ed] to 'blow up' and get angry about things."¹¹ Mojzis also reported that she was considering ways in which she could kill herself, including cutting her wrists. Natvig diagnosed Mojzis with major depressive disorder, recurrent and anxiety disorder. Natvig noted that Mojzis had "suicidal ideation and reports a plan of either cutting her wrists or taking an overdose of Trazodone."¹² Natvig concluded that Mojzis needed to be hospitalized and advised Mojzis' friend to take her to the St. Luke's Hospital Emergency Room in Cedar Rapids, Iowa.

Mojzis was admitted to St. Luke's Hospital on June 21, 2006 for depression and suicidal thoughts. At St. Luke's, Mojzis was treated with medications and supportive therapy. Over the course of her hospital stay, her mood improved and she started eating, feeling, and sleeping better. Mojzis was discharged on June 26, 2006 as improved at her

¹⁰ Dr. Tuetken noted, however, that "the exam did not reveal any significant muscle weakness or loss or change in reflexes." *Id.* at 276.

¹¹ *Id.* at 286.

¹² *Id.* at 287.

own request. Dr. Ali Safdar, M.D., recommended that Mojzis continue taking Lexapro, Zoloft, and Soma and get regular mental health treatment at the Abbe Center.

On July 7, 2006, Mojzis had an MRI of her cervical spine. The MRI showed degenerative changes in the cervical spine at C4-C5, C5-C6, and C6-C7. Specifically, the MRI showed “[m]ultiple level degenerative changes . . . with moderate left neural foraminal narrowing at C4-C5 and mild thecal sac narrowing and cord deformity, but no abnormal cord signal.”¹³ Dr. Tuetken concluded that although the MRI “is not normal, it is not clear that the changes seen here can account for her symptoms.”¹⁴

On November 7, 2006, Mojzis met with Dr. Jeffrey M. Clark, M.D., seeking relief for low back pain. Dr. Clark noted that Mojzis’ pain extends from her low back down both of her legs. Upon examination, Dr. Clark found Mojzis’ back to be “largely unremarkable” with mild to moderate tenderness in the low lumbar region. Dr. Clark further found that her leg strength was grossly normal, her reflexes were intact, and she had full range of motion. Dr. Clark diagnosed her with low back pain with some proximal left-sided radicular symptoms and evidence of spondylolisthesis of the lumbar spine. Dr. Clark recommended a trial epidural steroid injection as treatment, and the injection was administered that day. On December 14, 2006, Dr. Clark administered a transforaminal steroid injection to provide greater low back pain relief than the epidural steroid injection performed on November 7, 2006.¹⁵ On January 2, 2007, Mojzis received a third injection for low back pain relief.

On February 28, 2007, Mojzis had a follow-up appointment with Dr. Tuetken. Dr. Tuetken noted that:

¹³ See Administrative Record at 281.

¹⁴ *Id.*

¹⁵ According to the December 14, 2006 Operative Report, the epidural steroid injection gave Mojzis about two and one-half weeks of low back pain relief. See Administrative Record at 304.

[Mojzis] reports some improvement in hand pain with less numbness and tingling. Also some decrease in neck pain since undergoing physical therapy. However, her diffuse musculoskeletal pain remains unchanged and remains bothersome. She has frequent muscle cramps throughout the day and at night. Nighttime cramps greatly disturb her sleep. She is chronically fatigued. She remains depressed.

(Administrative Record at 313) Upon examination, Dr. Tuetken found Mojzis to be tearful and depressed. Her musculoskeletal exam revealed good neck range of motion; full shoulder, elbow, wrist, and finger range of motion; good hip, knee, and ankle movement; normal strength throughout; and diffuse tenderness consistent with fibromyalgia. Dr. Tuetken diagnosed her with: (1) Muscle cramps, (2) chronic sleep disturbance, secondary to muscle cramps, (3) depression, (4) vitamin D deficiency, (5) hypothyroidism with chronically elevated TSH, (6) fibromyalgia, secondary to 1-5, and (7) hypokalemia. Dr. Tuetken prescribed ergocalciferol to help her vitamin D deficiency, recommended she take a daily calcium supplement, and urged to be compliant with her synthroid medication as treatment.

V. CONCLUSIONS OF LAW

A. ALJ's Disability Determination

The ALJ determined that Mojzis is not disabled. In making this determination, the ALJ was required to complete the five-step sequential test provided in the social security regulations. *See* 20 C.F.R. § 404.1520(a)-(f); *Bowen v. Yuckert*, 482 U.S. 137, 140 (1987); *Page v. Astrue*, 484 F.3d 1040, 1042 (8th Cir. 2007); *Anderson v. Barnhart*, 344 F.3d 809, 812 (8th Cir. 2003). The five steps an ALJ must consider are:

(1) whether the claimant is gainfully employed, (2) whether the claimant has a severe impairment, (3) whether the impairment meets the criteria of any Social Security Income listings, (4) whether the impairment prevents the claimant from performing past relevant work, and (5) whether the impairment necessarily prevents the claimant from doing any other work.

Goff v. Barnhart, 421 F.3d 785, 790 (8th Cir. 2005) (citing *Eichelberger v. Barnhart*, 390 F.3d 584, 590 (8th Cir. 2004)); *see also* 20 C.F.R. § 404.1520(a)-(f). “If a claimant fails to meet the criteria at any step in the evaluation of disability, the process ends and the claimant is determined to be not disabled.” *Eichelberger*, 390 F.3d at 590-91 (citing *Ramirez v. Barnhart*, 292 F.3d 576, 580 (8th Cir. 2002)).

“To establish a disability claim, the claimant bears the initial burden of proof to show that he [or she] is unable to perform his [or her] past relevant work.” *Frankl v. Shalala*, 47 F.3d 935, 937 (8th Cir. 1995) (citing *Reed v. Sullivan*, 988 F.2d 812, 815 (8th Cir. 1993)). If the claimant meets this burden, the burden of proof then shifts to the Commissioner to demonstrate that the claimant retains the residual functional capacity to perform a significant number of other jobs in the national economy that are consistent with claimant’s impairments and vocational factors such as age, education, and work experience. *Id.* The RFC is the most an individual can do despite the combined effect of all of his or her credible limitations. 20 C.F.R. § 416.945. “‘It is the ALJ’s responsibility to determine a claimant’s RFC based on all relevant evidence, including medical records, observations of treating physicians and others, and claimant’s own descriptions of his [or her] limitations.’” *Tellez v. Barnhart*, 403 F.3d 953, 957 (8th Cir. 2005) (quoting *Pearsall v. Massanari*, 274 F.3d 1211, 1217 (8th Cir. 2001)).

The ALJ applied the first step of the analysis and determined that Mojzis had not engaged in substantial gainful activity since her alleged onset date, March 1, 2003. At the second step, the ALJ concluded that Mojzis had the following impairments “cervical and lumbar degenerative disc disease and depression.” At the third step, the ALJ found that Mojzis did not have “an impairment or combination of impairments that meets or medically equals one of the listed impairments in 20 C.F.R. [§] 404, [Appendix 1, Subpart P, Regulations No. 4 (the Listing of Impairments)].” At the fourth step, the ALJ determined Mojzis’ RFC as follows:

[Mojzis] has the residual functional capacity to lift no more than 20 pounds occasionally and no more than 10 pounds

frequently. She can stand and sit for 6 hours each in an 8-hour workday, and can occasionally climb stairs and ladders. She can frequently balance, stoop, kneel, crouch, crawl, and handle with the right hand. She can only occasionally be exposed to extremes of cold, humidity and wetness, and she should avoid hazards such as unprotected heights and moving hazardous machinery. Mentally, she can perform simple, routine tasks with only occasional changes in the routine work setting.

The ALJ determined that Mojzis had no past relevant work. At the fifth step, the ALJ determined that Mojzis, based on her age, education, and RFC, could work at jobs that exist in significant numbers in the national economy. Therefore, the ALJ concluded Mojzis was “not disabled.”

B. Whether the ALJ Fully and Fairly Developed the Record

Mojzis contends that the ALJ erred in three respects. First, Mojzis argues that the ALJ erred by failing to fully consider Dr. Tuetken’s opinions regarding her hand numbness. Next, Mojzis argues that the ALJ failed to fully and fairly develop the record with regard to Dr. Tuetken’s diagnosis of fibromyalgia. Lastly, Mojzis argues that the ALJ erred to fully consider Dr. Bauer’s opinions with regard to her depressive disorder and explain his own reasoning in determining her mental RFC assessment.

1. Hand Numbness

Mojzis argues that the ALJ failed to consider Dr. Tuetken’s opinions regarding the “nature and severity” of her hand pain and numbness. Specifically, Mojzis asserts that Dr. Tuetken’s opinions “provided at least two sources for [her] hand numbness--de Quervain’s tenosynovitis and cervical spine pathology.”¹⁶ Mojzis maintains that the ALJ erred by failing to mention or discuss either of these possibilities “in determining whether

¹⁶ See Mojzis’ Brief at 11.

the medical evidence supported [her] complaints of hand numbness.”¹⁷ Mojzis further argues that the ALJ failed to explain how he determined that her RFC included the ability to “frequently” handle with her right hand when Dr. Tuetken found multiple problems with both her right and left hands. Lastly, Mojzis argues that the ALJ “failed to include any limitations on grasping, gripping, or fingering with the right hand despite the documented loss of grip strength and inability to make a fist on [her] right hand.”¹⁸

An ALJ has the responsibility of assessing a claimant’s RFC, and his or her assessment must be based on all of the relevant evidence. *Guilliams*, 393 F.3d at 803; *see also Roberts v. Apfel*, 222 F.3d 466, 469 (8th Cir. 2000) (same). Relevant evidence for determining a claimant’s RFC includes “‘medical records, observations of treating physicians and others, and an individual’s own description of his [or her] limitations.’” *Lacroix v. Barnhart*, 465 F.3d 881, 887 (8th Cir. 2006) (quoting *Strongson v. Barnhart*, 361 F.3d 1066, 1070 (8th Cir. 2004)). However, “RFC is a medical question, and an ALJ’s finding must be supported by some medical evidence.” *Guilliams*, 393 F.3d at 803 (citing *Masterson v. Barnhart*, 363 F.3d 731, 738 (8th Cir. 2004)). In considering medical evidence, an ALJ may “‘reject the conclusions of any medical expert, whether hired by the claimant or the government, if they are inconsistent with the record as a whole.’” *Wagner v. Astrue*, 499 F.3d 842, 848 (8th Cir. 2007) (quoting *Pearsall*, 274 F.3d at 1219).

Moreover, the ALJ has a duty to develop the record fully and fairly. *Cox v. Astrue*, 495 F.3d 614, 618 (8th Cir. 2007); *Sneed v. Barnhart*, 360 F.3d 834, 838 (8th Cir. 2004); *Wilcutts v. Apfel*, 143 F.3d 1134, 1137 (8th Cir. 1998). Because an administrative hearing is a non-adversarial proceeding, the ALJ must develop the record fully and fairly in order

¹⁷ *Id.*

¹⁸ *Id.* at 11-12.

that “‘deserving claimants who apply for benefits receive justice.’” *Wilcutts*, 143 F.3d at 1138 (quoting *Battles v. Shalala*, 36 F.3d 43, 44 (8th Cir. 1994)).

The record reflects that on May 22, 2006, Dr. Tuetken examined Mojzis and found that her hand closure was somewhat limited and her grip strength was reduced bilaterally. Dr. Tuetken also found “marked tenderness over the right thumb extensors and abductors and Finkelstein’s sign for De Quervain’s tenosynovitis¹⁹ was very positive, right more than left.”²⁰ The ALJ’s RFC indicates that Mojzis is capable of light work.²¹ The ALJ does not, however, address Dr. Tuetken’s findings of Mojzis’ hand limitations.

Social Security Regulation 83-14 provides in pertinent part:

Unlike unskilled sedentary work, many unskilled light jobs do not entail fine use of the fingers. Rather, they require gross use of the hands to grasp, hold, and turn objects. Any limitation on these functional abilities must be considered very carefully to determine its impact on the size of the remaining occupational base of a person who is otherwise found functionally capable of light work.

(SSR 83-14) In light of SSR 83-14 and Dr. Tuetken’s findings, the Court finds that the ALJ failed to fully and fairly develop the record with regard to Mojzis’ hand limitations. *See Cox*, 495 F.3d at 618; *see also Williams*, 393 F.3d at 803 (an ALJ’s RFC assessment must be based on all of the relevant evidence). Accordingly, the Court determines that remand is appropriate. On remand, the ALJ must fully and fairly develop the record with

¹⁹ “In de Quervain’s tenosynovitis, the sheath of the tendons on the thumb side of your wrist becomes inflamed or swollen, restricting the tendons’ movement. The result with de Quervain’s tenosynovitis is discomfort and pain every time you turn your wrist, grasp anything or make a fist.” *See* <http://www.mayoclinic.com/health/de-quervains-tenosynovitis/DS00692>

²⁰ *See* Administrative Record at 275.

²¹ *Id.* at 19 (“Although the state agency medical consultant decreased her residual functional capacity to medium work, the undersigned [ALJ] has viewed the evidence in the light most favorable to the claimant in decreasing it even further to light work.”).

regard to findings of Dr. Tuetken as they relate to Mojzis' hand problems. Specifically, the ALJ shall explain his reasons for accepting or rejecting Dr. Tuetken's findings. The ALJ should also address the reasons for his determination that Mojzis' RFC included the ability to "frequently handle" with her right hand and discuss the effect Dr. Tuetken's findings have on that determination.

2. *Fibromyalgia*

Mojzis argues that the ALJ failed to fully and fairly develop the record with regard to Dr. Tuetken's diagnosis of fibromyalgia. Mojzis maintains that instead of finding Dr. Tuetken's diagnosis medically indeterminable, the ALJ should have sought clarification from Dr. Tuetken as to the medical evidence for her diagnosis. In the alternative, Mojzis argues that the ALJ should have ordered a consultative examination to determine whether she met the criteria for fibromyalgia.

In his decision, the ALJ determined:

The record contains a diagnosis by Rebecca Teutken [(sic)], M.D. of fibromyalgia but this impairment is not medically determinable. The undersigned [ALJ] notes that a claimant's subjective statements must be supported by medical signs and laboratory findings which document medical impairments that could reasonably be expected to cause the pain and other symptoms he alleges. . . . Although Dr. Teutken [(sic)] is a rheumatologist, trigger points and other objective findings consistent with fibromyalgia are not documented.

(Administrative Record at 15)

The record provides that Dr. Tuetken examined Mojzis on May 22, 2006. Dr. Tuetken noted that Mojzis had a long history of diffuse musculoskeletal pain, and she had previously been diagnosed with fibromyalgia. After examining her, Dr. Tuetken diagnosed Mojzis with "long-standing" fibromyalgia. On February 28, 2007, Dr. Tuetken examined Mojzis a second time. Dr. Tuetken noted that Mojzis continued to have diffuse musculoskeletal pain, including muscle cramps, nighttime cramps which disturbed her

sleep, and chronic fatigue. Upon examination, Dr. Tuetken concluded that Mojzis had diffuse tenderness consistent with fibromyalgia²².

An ALJ has a duty to develop the record fully and fairly. *Cox v. Astrue*, 495 F.3d 614, 618 (8th Cir. 2007); *Sneed v. Barnhart*, 360 F.3d 834, 838 (8th Cir. 2004); *Wilcutts v. Apfel*, 143 F.3d 1134, 1137 (8th Cir. 1998). Because an administrative hearing is a non-adversarial proceeding, the ALJ must develop the record fully and fairly in order that “deserving claimants who apply for benefits receive justice.” *Wilcutts*, 143 F.3d at 1138 (quoting *Battles v. Shalala*, 36 F.3d 43, 44 (8th Cir. 1994)).

Additionally, an ALJ is not required to “seek additional clarifying statements from a treating physician unless a crucial issue is undeveloped.” *Stormo v. Barnhart*, 377 F.3d 801, 806 (8th Cir. 2004) (citation omitted). An ALJ should only contact a treating physician “if the doctor’s records are ‘inadequate for us to determine whether the claimant is disabled’ such as ‘when the report does not contain all the necessary information, or does not appear to be based on medically acceptable clinical and laboratory diagnostic techniques.’” *Goff*, 421 F.3d at 791 (citing 20 C.F.R. §§ 404.1512(e) and 416.912(e)). An ALJ may also order medical examinations and tests when the medical records presented to him or her constitute insufficient medical evidence to determine whether the claimant is disabled. *Barrett v. Shalala*, 38 F.3d 1019, 1023 (8th Cir. 1994) (citation omitted); *see also* 20 C.F.R. § 404.1519a(a)(1) (“The decision to purchase a consultative examination . . . will be made after we have given full consideration to whether the additional information needed is readily available from the records of your medical sources.”). Additionally, 20 C.F.R. § 404.1519a(b) provides that “[a] consultative examination may be purchased when the evidence as a whole, both medical and nonmedical, is not sufficient to support a decision on . . . [the] claim.” *Id.* For example, a consultative examination

²² *See* Administrative Record at 314 (“[Mojzis] has diffuse tenderness consistent with fibromyalgia.”). Additionally, Dr. Tuetken also diagnosed Mojzis with muscle cramps and chronic sleep disturbance.

should be purchased when “[t]he additional evidence needed is not contained in the records of your medical sources.” 20 C.F.R. § 404.1519a(b)(1).

According to the Eighth Circuit Court of Appeals, fibromyalgia:

is pain in the fibrous connective tissue components of muscles, tendons, ligaments, and other white connective tissues, [which] can be disabling. It often leads to a distinct sleep derangement which often contributes to a general cycle of daytime fatigue and pain.

Kelley v. Callahan, 133 F.3d 583, 589 (8th Cir. 1998) (citing *Cline v. Sullivan*, 939 F.2d 560, 563-67 (8th Cir. 1991)); *see also Brosnahan v. Barnhart*, 336 F.3d 671, 672, n.1 (8th Cir. 2003) (“[F]ibromyalgia is diagnosed based on widespread pain with tenderness in at least eleven of eighteen sites known as trigger points.”).

Here, the ALJ correctly noted that Dr. Tuetken’s diagnosis of fibromyalgia was not supported by the trigger point test. In addition to diagnosing Mojzis with fibromyalgia, however, Dr. Tuetken also diagnosed her with chronic neck and back pain, muscle cramps, and chronic sleep disturbance. Dr. Tuetken also noted that Mojzis suffered from chronic fatigue and diffuse tenderness consistent with fibromyalgia. These diagnoses are consistent with symptoms of fibromyalgia. *See Kelley*, 133 F.3d at 589. Thus, after reviewing the record, the Court concludes that “a crucial issue is undeveloped.” *See Stormo*, 377 F.3d at 806. The Court finds that the record is inadequate for determining whether Mojzis was accurately diagnosed with fibromyalgia. On remand, the ALJ must fully develop the record on the issue of Mojzis’ fibromyalgia diagnosis, and should recontact Dr. Tuetken to seek clarification of the reasons and medical evidence which support Dr. Tuetken’s determination that Mojzis’ suffers from fibromyalgia. Additionally, if after recontacting Dr. Tuetken, further examination is necessary to provide a complete record on the issue of Mojzis’ fibromyalgia, then a consultative examination should be purchased. *See Barrett*, 38 F.3d at 1023; 20 C.F.R. § 404.1519a.

3. Depression

Mojzis argues that the ALJ's findings regarding her depression are internally inconsistent and not supported by substantial evidence. Specifically, Mojzis claims that the ALJ erred by failing to impose any limitations on social functioning in her mental RFC assessment. Mojzis also argues that the ALJ failed to fully and fairly consider the opinions of Dr. Bauer, a psychologist who provided DDS with mental RFC and Psychiatric Review Technique assessments.

In his decision, the ALJ found that Mojzis:

has the following degree of limitation in the broad areas of functioning set out in the disability regulations for evaluating mental disorders and in the mental disorders listings in 20 CFR, Part 404, Subpart P, Appendix 1: mild restriction of activities of daily living; moderate difficulties in maintaining social functioning; moderate difficulties in maintaining concentration, persistence or pace; and one or two episodes of decompensation.

(Administrative Record at 18) In his RFC assessment, however, the ALJ determined that Mojzis “[m]entally . . . can perform simple, routine tasks with only occasional changes in the routine work setting.”²³

The record provides that Dr. Bauer, a psychological consultant, made a mental RFC assessment in which he found that Mojzis was moderately limited in her ability to: understand and remember detailed instructions; carry out detailed instructions; maintain attention and concentration for extended periods; perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances; complete a normal workday and workweek without interruptions from psychologically based symptoms and perform at a consistent pace without an unreasonable number and length of rest periods; accept instructions and respond appropriately to criticism from supervisors; and respond appropriately to changes in the work setting. Additionally, like the ALJ,

²³ See Administrative Record at 15.

Dr. Bauer also found that Mojzis had mild restriction of activities of daily living; moderate difficulties in maintaining social functioning; and moderate difficulties in maintaining concentration, persistence or pace.

An ALJ has the responsibility of assessing a claimant's RFC, and his or her assessment must be based on all of the relevant evidence. *Guilliams*, 393 F.3d at 803; *see also Roberts v. Apfel*, 222 F.3d 466, 469 (8th Cir. 2000) (same). Relevant evidence for determining a claimant's RFC includes "medical records, observations of treating physicians and others, and an individual's own description of his [or her] limitations.'" *Lacroix v. Barnhart*, 465 F.3d 881, 887 (8th Cir. 2006) (quoting *Strongson v. Barnhart*, 361 F.3d 1066, 1070 (8th Cir. 2004)). Additionally, "[s]tate agency . . . psychological consultants . . . are highly qualified . . . psychologists who are experts in Social Security disability evaluation. Therefore, administrative law judges must consider findings of state agency . . . psychological consultants . . . as opinion evidence." 20 C.F.R. § 404.1527(f)(2)(I). Moreover, the ALJ has a duty to develop the record fully and fairly. *Cox v. Astrue*, 495 F.3d 614, 618 (8th Cir. 2007); *Sneed v. Barnhart*, 360 F.3d 834, 838 (8th Cir. 2004); *Wilcutts v. Apfel*, 143 F.3d 1134, 1137 (8th Cir. 1998). Because an administrative hearing is a non-adversarial proceeding, the ALJ must develop the record fully and fairly in order that "deserving claimants who apply for benefits receive justice.'" *Wilcutts*, 143 F.3d at 1138 (quoting *Battles v. Shalala*, 36 F.3d 43, 44 (8th Cir. 1994)).

After reviewing the entire record, the Court finds that the ALJ's decision, particularly the ALJ's assessment of Mojzis' mental RFC, lacks any discussion of Dr. Bauer's findings or his own findings of Mojzis' limitations with regard to social functioning and maintaining concentration, persistence or pace. Therefore, the Court determines that the ALJ's RFC assessment was not based on all of the relevant medical evidence. *See Guilliams*, 393 F.3d at 803; *Roberts*, 222 F.3d at 469. Accordingly, the Court concludes that remand is appropriate. On remand, the ALJ must fully and fairly develop the record with regard to the opinions of Dr. Bauer and the effect Dr. Bauer's

opinions may or may not have Mojzis' RFC. *See Cox*, 495 F.3d at 618. Specifically, the ALJ shall explain his reasons for accepting or rejecting Dr. Bauer's opinions and explain his own findings with regard to Mojzis' mental capabilities, including social functioning and her ability to maintain concentration, persistence or pace.

C. Reversal or Remand

The scope of review of the Commissioner's final decision is set forth in 42 U.S.C. § 405(g) which provides in pertinent part:

The court shall have the power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Secretary, with or without remanding the cause for a rehearing.

42 U.S.C. § 405(g). The Eighth Circuit Court of Appeals has stated that:

Where the total record is overwhelmingly in support of a finding of disability and the claimant has demonstrated his [or her] disability by medical evidence on the record as a whole, we find no need to remand.

Gavin v. Heckler, 811 F.2d 1195, 1201 (8th Cir. 1987); *see also Beeler v. Brown*, 833 F.2d 124, 127 (8th Cir. 1987) (finding reversal of denial of benefits was proper where "the total record overwhelmingly supports a finding of disability"); *Stephens v. Sec'y of Health, Educ., & Welfare*, 603 F.2d 36, 42 (8th Cir. 1979) (explaining that reversal of denial of benefits is justified where no substantial evidence exists to support a finding that the claimant is not disabled). In the present case, the Court concludes that the medical records as a whole do not "overwhelmingly support a finding of disability." *Beeler*, 833 F.2d at 127. Instead, the ALJ simply failed to fully and fairly develop the record with regard to the medical opinions of Drs. Tuetken and Bauer. Accordingly, the Court finds that remand is appropriate.

VI. CONCLUSION

The Court concludes that this matter should be remanded to the Commissioner for further proceedings. On remand, the ALJ should develop the record fully and fairly with

regard to the opinions of Drs. Tuetken and Bauer. Specifically, the ALJ shall explain the reasons for his determination that Mojzis' RFC included the ability to "frequently handle" with her right hand in relation to Dr. Tuetken's findings regarding Mojzis' hand problems. The ALJ should also fully develop the record on the issue of Mojzis' fibromyalgia diagnosis and recontact Dr. Tuetken to seek clarification of the reasons and medical evidence which support her determination that Mojzis suffers from fibromyalgia. Lastly, the ALJ should explain his reasons for accepting or rejecting Dr. Bauer's opinions and explain his own findings with regard to Mojzis' mental capabilities, including social functioning and her ability to maintain concentration, persistence or pace.

VII. ORDER

For the foregoing reasons, it is hereby **ORDERED**:

This matter is **REVERSED** and **REMANDED** to the Commissioner of Social Security pursuant to sentence four of 42 U.S.C. § 405(g), for further proceedings as discussed herein.

DATED this 23rd day of May, 2008.



JON STUART SCOLES
United States Magistrate Judge
NORTHERN DISTRICT OF IOWA