

TO BE PUBLISHED

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

MARK BRYAN MATHIES,

Plaintiff,

vs.

CAROLYN W. COLVIN, Acting
Commissioner of Social Security,

Defendant.

No. C13-4071-MWB

**REPORT AND
RECOMMENDATION**

Plaintiff Mark Bryan Mathies seeks judicial review of a final decision of the Commissioner of Social Security (the Commissioner) denying his application for Social Security Disability benefits (DIB) under Title II of the Social Security Act, 42 U.S.C. § 401 *et seq.* (Act). Mathies contends that the administrative record (AR) does not contain substantial evidence to support the Commissioner's decision that he was not disabled during the relevant period of time. For the reasons that follow, I recommend that the Commissioner's decision be reversed and remanded for further proceedings.

I. BACKGROUND

Mathies was born in 1960. AR 187. He has a high school diploma and past relevant work as a refrigeration mechanic. AR 59-60, 309. He filed an application for DIB on May 24, 2011, alleging disability since October 31, 2006. AR 77, 187-95. His application was denied initially. AR 82-90. Mathies requested reconsideration and on April 24, 2012, the Social Security Administration (SSA) issued a Notice of Award finding Mathies was disabled since October 31, 2006, but was only entitled to benefits

beginning in May 2010 due to the date of his application. AR 92-100. Confusingly, however, a separate “explanation of determination” stated that Mathies was found disabled as of February 2, 2011. AR 79.

On June 7, 2012, Mathies requested reopening of prior DIB applications that had been denied in 2008 and 2009 and asked for a hearing before an Administrative Law Judge (ALJ) on the issue of whether those applications should be reopened based on new and material evidence. AR 101. On August 3, 2012, he requested that a fully favorable decision be made on his claim finding him disabled back to his alleged onset date and reopening his prior applications for benefits. AR 102-05

A hearing was held before ALJ Emily Cameron Shattil on February 27, 2013. AR 48-75. Mathies testified, as did a medical expert and a vocational expert (VE). During the hearing, Mathies amended his alleged onset date to June 1, 2010. AR 51. This rendered his request to reopen the earlier applications moot. Mathies testified that he is unable to work due to (a) pain in his lower back and feet, (b) a diminished capacity for exertion caused by a heart condition and (c) arthritis. AR 61-66.

On March 13, 2013, the ALJ found that Mathies was not disabled at any time from June 1, 2010, through the date he was last insured, effectively reversing the prior decision in his favor. AR 7-32. The Appeals Council denied Mathies’s request for review on June 6, 2013. AR 1-6. The ALJ’s decision thus became the final decision of the Commissioner. AR 1; 20 C.F.R. § 404.981.

On August 1, 2013, Mathies filed a complaint (Doc. No. 2) in this court seeking review of the Commissioner’s decision. This case has been referred to me pursuant to 28 U.S.C. § 636(b)(1)(B) for the filing of a report and recommended disposition. The parties have briefed the issues and the matter is now fully submitted.

II. DISABILITY DETERMINATIONS AND THE BURDEN OF PROOF

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

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

Second, if the claimant is not engaged in substantial gainful activity, the Commissioner looks to see “whether the claimant has a severe impairment that significantly limits the claimant’s physical or mental ability to perform basic work activities.” *Dixon v. Barnhart*, 353 F.3d 602, 605 (8th Cir. 2003). “An impairment is not severe if it amounts only to a slight abnormality that would not significantly limit the claimant’s physical or mental ability to do basic work activities.” *Kirby*, 500 F.3d at 707; *see* 20 C.F.R. §§ 404.1520(c), 404.1521(a).

The ability to do basic work activities is defined as “the abilities and aptitudes necessary to do most jobs.” 20 C.F.R. § 404.1521(b). These abilities and aptitudes include (1) physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; (2) capacities for seeing, hearing, and speaking; (3)

understanding, carrying out, and remembering simple instructions; (4) use of judgment; (5) responding appropriately to supervision, co-workers, and usual work situations; and (6) dealing with changes in a routine work setting. *Id.* § 404.1521(b)(1)-(6); *see Bowen v. Yuckert*, 482 U.S. 137, 141, 107 S. Ct. 2287, 2291 (1987). “The sequential evaluation process may be terminated at step two only when the claimant’s impairment or combination of impairments would have no more than a minimal impact on her ability to work.” *Page v. Astrue*, 484 F.3d 1040, 1043 (8th Cir. 2007) (internal quotation marks omitted).

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

Fourth, if the claimant’s impairment is severe, but it does not meet or equal one of the presumptively disabling impairments, then the Commissioner will assess the claimant’s 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(a)(4)(iv), 404.1545(a)(4). “RFC is a medical question defined wholly in terms of the claimant’s physical ability to perform exertional tasks or, in other words, what the claimant can still do despite his or her physical or mental limitations.” *Lewis v. Barnhart*, 353 F.3d 642, 646 (8th Cir. 2003) (internal quotation marks omitted); *see* 20 C.F.R. § 404.1545(a)(1). The claimant is responsible for providing evidence the Commissioner will use to make a finding as to the claimant’s RFC, but the Commissioner is responsible for developing the claimant’s “complete medical history, including arranging for a consultative examination(s) if necessary, and making every reasonable effort to help [the claimant] get medical reports from [the claimant’s] own medical sources.” 20 C.F.R. § 404.1545(a)(3). The Commissioner also

will consider certain non-medical evidence and other evidence listed in the regulations. *See id.* If a claimant retains the RFC to perform past relevant work, then the claimant is not disabled. *Id.* § 404.1520(a)(4)(iv).

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

III. ALJ'S FINDINGS

The ALJ made the following findings:

- (1) The claimant last met the insured status requirements of the Social Security Act on December 31, 2011.
- (2) The claimant did not engage in substantial gainful activity during the period from his amended alleged onset date of June 1, 2010 through his date last insured of December 31, 2011 (20 CFR 404.1571 *et seq.*).
- (3) Through the date last insured, the claimant had the following severe impairments: chronic atrial fibrillation; history of congestive heart failure;

hypertensive heart disease; obesity; status post left ankle fracture and open reduction and fixation; mild poly neuropathy; benign positional vertigo; degenerative disc disease of the lumbar spine; and cervical spine arthritis with congenital fusion and spondylosis at the C4 through C6 levels (20 CFR 404.1520(c)).

- (4) Through the date last insured, the claimant did not have an impairment or combination of impairments that met or medically equaled the severity of one of the listed impairments in 20 CFR Part 404, Subpart P, Appendix 1 (20 CFR 404.1520(d), 404.1525, 404.1526).
- (5) After careful consideration of the entire record, the undersigned finds that, through the date last insured, the claimant had the residual functional capacity to lift and carry twenty pounds on occasion and ten pounds frequently. He was able to sit, stand or walk (any), each, for two hours continuously and for a total of six hours in an eight-hour workday. The claimant is able to perform work that does not require climbing ladders, ropes or scaffolding; or more than occasional climbing of stairs, stooping, kneeling, crawling or crouching.
- (6) Through the date last insured, the claimant was unable to perform any past relevant work (20 CFR 404.1565).
- (7) The claimant was born on June 21, 1960 and was 51 years old, which is defined as an individual closely approaching advanced age, on the date last insured (20 CFR 404.1563).
- (8) The claimant has at least a high school education and is able to communicate in English (20 CFR 404.1564).
- (9) Transferability of job skills is not material to the determination of disability because using the Medical-Vocational Rules as a framework supports a finding that the claimant is “not disabled,” whether or not the claimant has transferable job skills (See SSR 82-41 and 20 CFR Part 404, Subpart P, Appendix 2).

- (10) Through the date last insured, considering the claimant's age, education, work experience, and residual functional capacity, there were jobs that existed in significant numbers in the national economy that the claimant could have performed (20 CFR 404.1569 and 404.1569(a)).
- (11) The claimant was not under a disability, as defined in the Social Security Act, at any time from June 1, 2010, through December 31, 2011, the date last insured (20 CFR 404.1520(g)).

AR 10-25.

IV. THE SUBSTANTIAL EVIDENCE STANDARD

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

In determining whether the Commissioner's decision meets this standard, the court considers "all of the evidence that was before the ALJ, but it [does] not re-weigh the evidence." *Vester v. Barnhart*, 416 F.3d 886, 889 (8th Cir. 2005). The court considers both evidence which supports the Commissioner's decision and evidence that detracts from it. *Kluesner v. Astrue*, 607 F.3d 533, 536 (8th Cir. 2010). The court must "search the record for evidence contradicting the [Commissioner's] decision and give that

evidence appropriate weight when determining whether the overall evidence in support is substantial.” *Baldwin v. Barnhart*, 349 F.3d 549, 555 (8th Cir. 2003) (citing *Cline v. Sullivan*, 939 F.2d 560, 564 (8th Cir. 1991)).

In evaluating the evidence in an appeal of a denial of benefits, the court must apply a balancing test to assess any contradictory evidence. *Sobania v. Sec’y of Health & Human Servs.*, 879 F.2d 441, 444 (8th Cir. 1989). The court, however, does not “reweigh the evidence presented to the ALJ,” *Baldwin*, 349 F.3d at 555 (citing *Bates v. Chater*, 54 F.3d 529, 532 (8th Cir. 1995)), or “review the factual record de novo.” *Roe v. Chater*, 92 F.3d 672, 675 (8th Cir. 1996) (citing *Naber v. Shalala*, 22 F.3d 186, 188 (8th Cir. 1994)). Instead, if, after reviewing the evidence, the court finds it “possible to draw two inconsistent positions from the evidence and one of those positions represents the Commissioner’s findings, [the court] must affirm the [Commissioner’s] denial of benefits.” *Kluesner*, 607 F.3d at 536 (quoting *Finch v. Astrue*, 547 F.3d 933, 935 (8th Cir. 2008)). This is true even in cases where the court “might have weighed the evidence differently.” *Culbertson*, 30 F.3d at 939 (quoting *Browning v. Sullivan*, 958 F.2d 817, 822 (8th Cir. 1992)). The court may not reverse the Commissioner’s decision “merely because substantial evidence would have supported an opposite decision.” *Baker v. Heckler*, 730 F.2d 1147, 1150 (8th Cir. 1984); see *Goff v. Barnhart*, 421 F.3d 785, 789 (8th Cir. 2005) (“[A]n administrative decision is not subject to reversal simply because some evidence may support the opposite conclusion.”).

V. DISCUSSION

Mathies argues the ALJ’s decision is not supported by substantial evidence for the following reasons: (a) the ALJ failed to follow the treating physician rule; and (b) the ALJ failed to properly evaluate his credibility. I will discuss these arguments separately.

A. *The Treating Physician Rule*

Mathies argues that the ALJ erred by deciding to give little weight to opinions provided by two treating sources, (1) Scott Hoffman, D.O, a family medicine physician, and (b) W. Paul Biddle, M.D., a cardiologist. The Commissioner disagrees, arguing that the ALJ's weighting of the various medical opinions is supported by substantial evidence and that the ALJ provided good reasons for discrediting Dr. Hoffman's and Dr. Biddle's opinions.

1. *Applicable Standards*

The Social Security regulations state, in relevant part:

Treatment relationship. Generally, we give more weight to opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations. If we find that a treating source's opinion on the issue(s) of the nature and severity of your impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight. When we do not give the treating source's opinion controlling weight, we apply the factors listed in paragraphs (c)(2)(i) and (c)(2)(ii) of this section, as well as the factors in paragraphs (c)(3) through (c)(6) of this section in determining the weight to give the opinion. We will always give good reasons in our notice of determination or decision for the weight we give your treating source's opinion.

20 C.F.R. § 404.1527(c)(2) [emphasis added]. What this means is that a treating physician's opinion is generally given controlling weight, but is not inherently entitled to it. *Hacker v. Barnhart*, 459 F.3d 934, 937 (8th Cir. 2006). A treating physician's opinion “does not automatically control or obviate the need to evaluate the record as [a] whole.” *Leckenby v. Astrue*, 487 F.3d 626, 632 (8th Cir. 2007). But that opinion will

be given controlling weight if it is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the case record. *Hacker*, 459 F.3d at 937.

When a treating physician's opinion is entitled to controlling weight, the ALJ must defer to the physician's medical opinions about the nature and severity of an applicant's impairments, including symptoms, diagnosis and prognosis, what an applicant is capable of doing despite the impairment, and the resulting restrictions. 20 C.F.R. § 404.1527(a)(2); *Ellis v. Barnhart*, 392 F.3d 988, 995 (8th Cir. 2005). The ALJ must "always give good reasons" for the weight given to a treating physician's evaluation." 20 C.F.R. § 404.1527(c)(2); *see also Davidson v. Astrue*, 501 F.3d 987, 990 (8th Cir. 2007). A treating physician's conclusion that an applicant is "disabled" or "unable to work" addresses an issue that is reserved for the Commissioner and therefore is not a "medical opinion" that must be given controlling weight. *Ellis*, 392 F.3d at 994.

If a treating physician's opinion is not entitled to controlling weight, the regulations outline factors for the ALJ to consider in deciding what amount of weight to give it:

When we do not give the treating source's opinion controlling weight, we apply the factors listed in paragraphs (c)(2)(i) and (c)(2)(ii) of this section, as well as the factors in paragraphs (c)(3) through (c)(6) of this section in determining the weight to give the opinion.

20 C.F.R. § 404.1527(c)(2). Those factors are:

- (i) Length of the treatment relationship and the frequency of examination.
- (ii) Nature and extent of the treatment relationship.
- (iii) Supportability.
- (iv) Consistency [with the record as a whole].
- (v) Specialization.
- (vi) Other factors [which tend to support or contradict the opinion].

20 C.F.R. § 404.1527(c).

2. *Analysis*

a. *Overview of treating source opinions*

i. *Dr. Hoffman*

Dr. Hoffman began treating Mathies in 2005. AR 1542. On November 15, 2010, he evaluated Mathies for a pre-employment physical. AR 806. Mathies reported that he had been working at Broadway Elementary for four days doing custodial work but stated that he was not able to be very active because his atrial fibrillation “still acts up.” *Id.* Mathies also reported having shortness of breath and that his heart pounded when walking up two flights of stairs. *Id.* Examination revealed an irregular heartbeat and lower extremity 1+ edema, left greater than right. *Id.* Dr. Hoffman then wrote:

A/P: Denison Broadway Elementary School employment physical. I signed the form. He stated that if kept doing the duty that he is doing now he would be okay. I told him that with his heart the way it is he cannot exert himself a lot. I don't think he would be able to do any snow shoveling. He really should not do much heavy lifting. He knows this and he is going to talk to his employer about it. I told him that he would have to be careful and rest when he needs it. He was afraid that if I put restrictions on him that he may not be able to work. It is good for him to get out and do some kind of work.

Id.

On June 23, 2011, Dr. Hoffman examined Mathies and completed a Multiple Impairment Questionnaire. AR 1540-48. He reported treating Mathies since September 2005 for chronic atrial fibrillation, obstructive sleep apnea, obesity, hypertensive heart disease, hypertension, history of congestive heart failure, chronic alcohol abuse, gout, chronic low back pain, vertigo, neck pain, and lower extremity neuropathy. AR 1542. He stated that Mathies’s prognosis was “poor.” *Id.* Dr. Hoffman reported that Mathies had undergone numerous cardioversions, antiarrhythmic trials, and ablation without success and his symptoms were not controlled “with any kid of modality.” AR 1540. He also noted that Mathies experienced cardiac symptoms with minimal exertion and could only perform light work for 10-15 minutes and then had to rest for at least 5-10 minutes and sometimes up to 30 minutes, depending on the severity of his symptoms.

Id. Dr. Hoffman indicated that Mathies had tried to work as a school custodian but worked only about 4 to 8 hours per month, indicating that he had to rest after 15 minutes of work because of his cardiac symptoms. *Id.*

Dr. Hoffman further reported that Mathies's primary symptoms were fatigue, palpitations and shortness of breath with exertion, low back pain, neck pain, left ankle pain and numbness and tingling in his feet. AR 1543. He stated that Mathies's chronic pain occurred daily and was worsened by bending, lifting, sitting and sudden movement. AR 1544. Dr. Hoffman opined that in an 8-hour workday, Mathies could sit for 3 hours total, stand/walk for 1 hour total, frequently lift up to 5 pounds, and occasionally lift/carry up to 20 pounds. AR 1544-45. He noted significant limitations on repetitive lifting because Mathies experienced shortness of breath easily and had back pain. AR 1545. He found marked limitations (defined as essentially precluded) in the ability to use the right upper extremity to grasp, turn, and twist objects and in the ability to use the bilateral upper extremities for reaching, including overhead. AR 1545-46.

Dr. Hoffman also reported that Mathies continued to have chronic low and mid back pain, neck pain, and left ankle pain despite taking medication and having physical therapy and chiropractic treatment. AR 1540. He indicated that Mathies's symptoms were frequently severe enough to interfere with attention and concentration and that Mathies was only capable of tolerating low physical stress that was not sustained for longer than 10 minutes at a time. AR 1547. He stated that during an 8-hour workday, Mathies would require unscheduled rest breaks every 15-20 minutes for an average of 30 minutes each before returning to work. *Id.* In addition, Dr. Hoffman estimated that Mathies would likely be absent from work more than three times a month as a result of his impairments or treatment. AR 1548.

On June 28, 2012, Dr. Hoffman completed a narrative report in which he updated his opinion concerning Mathies's symptoms and limitations. AR 1709-10. He indicated that Mathies was unable to perform full-time competitive employment during the period from October 31, 2006, through December 31, 2011. AR 1710.

ii. Dr. Biddle

Dr. Biddle began treating Mathies in 2006. AR 1533. On June 22, 2011, Dr. Biddle completed a letter and Multiple Impairment Questionnaire in which he reported treating Mathies for permanent atrial fibrillation that was first diagnosed in 2006. AR 1532-38. He stated that Mathies's condition had been very difficult to control and that he developed recurrent atrial fibrillation despite treatment with electrical cardioversion on several occasions. AR 1532. He also stated that Mathies could not tolerate the "most potent anti-arrhythmic agent" available and was instead prescribed a regimen of medications to control his heart rate, but still continued to suffer from "exertional shortness of breath, palpitations and fatigue." *Id.* Dr. Biddle indicated that these symptoms occurred even with normal daily activities. *Id.* He opined that Mathies could not perform employment that required physical effort and that changes in posture would cause dizziness because of the side effects of his medications. *Id.* Dr. Biddle estimated that during an 8-hour workday, Mr. Mathies could only sit for one hour total, stand/walk for one hour or less, and only occasionally lift/carry up to 20 pounds. AR 1535-1536.

Dr. Biddle further reported that Mathies would have good days and bad days, estimating that he would be absent from work two to three times a month due to his impairments or treatment. AR 1536. He found that Mathies's symptoms had progressed since 2006 and were frequently severe enough to interfere with attention and concentration. AR 1536-37. He indicated that Mathies was incapable of tolerating even low stress. AR 1536.

Dr. Biddle saw Mathies again on December 27, 2011. He found that Mathies's cardiac symptoms of exertional dyspnea and fatigue were unchanged at that time. AR 1667. Examination revealed an irregular heart rate and variable first heart sound. *Id.*

b. The ALJ's reasoning

The ALJ began by summarizing the medical evidence concerning Dr. Hoffman's and Dr. Biddle's treatment of Mathies. AR 17-20. With regard to Dr. Hoffman, the

ALJ discussed his treatment of back pain, foot pain and ankle pain. She noted that in 2006, Hoffman limited Mathies to lifting no more than 25 pounds due to back pain but did not otherwise restrict him from full-time work. AR 17 (referring to AR 321-44¹). While acknowledging that this finding was made prior to the alleged onset date, the ALJ found it significant because “later objective evidence shows [Mathies’s back condition] did not change substantially between March 2006 and December 2012.” *Id.*

The ALJ then referenced a December 2008 examination during which Mathies complained of low back pain but Dr. Hoffman noted no signs of impairment and stated that Mathies had a good range of motion and only “some” pain. AR 19 (referring to AR 814). During that visit, Dr. Hoffman recommended conservative treatment, such as a heating pad and Tylenol. AR 814. Dr. Hoffman offered to prescribe a pain-relief medication, such as Ultram, but Mathies declined. *Id.*

The ALJ stated that the record is “essentially silent” about back pain from December 2008 until April 2011, when Mathies told Dr. Hoffman that he had “a lot of pain in the mid lateral back and some in the left lower back.” AR 19 (referring to AR 804). However, the ALJ failed to note that during a December 2010 examination, Mathies told Dr. Hoffman that he has “chronic back pain” and asked for pain medication. AR 805. At that time, Dr. Hoffman prescribed Tramadol. *Id.*

During the April 2011 examination, Dr. Hoffman found that Mathies was suffering from a virus – possibly influenza – that was making his back pain worse. AR 804. Dr. Hoffman reported that Mathies did not “have much pain with palpation in his back” but “does get some pain in the right lateral back” when twisting. *Id.* Dr. Hoffman advised Mathies to continue to use Tramadol or Tylenol for his back pain. *Id.* The ALJ then stated that Mathies made no further report of back pain until November 2012, at which

¹ The ALJ’s ruling cites only to exhibits, without specifying which page or pages of each exhibit the ALJ actually relied on in support of a stated fact. Many of the exhibits are quite lengthy. When I indicate that the ALJ was “referring to” particular pages, I am providing my best guess as to the specific pages the ALJ had in mind.

time physical therapy was attempted but discontinued due to lack of improvement. AR 19. An MRI taken the following month was nearly identical to one taken in 2006, as only “slight” changes were noted. *Id.* (referring to AR 1770-71).

As for foot and ankle pain, the ALJ described various examinations by Dr. Hoffman, starting in December 2009, during which Mathies described left ankle pain and bilateral foot pain. *Id.* She noted that Dr. Hoffman attributed Mathies’s foot pain to bilateral plantar fasciitis but later suggested that it may be caused by gout and exacerbated by Mathies’s use of alcohol. *Id.* (referring to AR 808-10). The ALJ next observed that Mathies made no further report to Dr. Hoffman about foot or ankle pain for some period of time. *Id.* She stated that the medical evidence shows that no further explanation of potential causes of foot or ankle pain were explored. *Id.*

With regard to Dr. Biddle, the ALJ stated that his medical records include observations that Mathies’s heart condition was stable and was not causing serious symptoms. AR 17-18. However, two of the three quotations the ALJ attributed to Dr. Biddle were actually authored by other sources. A comment in May 2007 that Mathies’s atrial fibrillation was “brief and asymptomatic” was made by Dennis Esterbrooks, M.D., not by Dr. Biddle. AR 423-24. A comment in March 2010 that atrial fibrillation was “not bothering him much” was made by Kelly Airey, M.D., not by Dr. Biddle. AR 870-71. It appears that the ALJ correctly attributed only one comment to Dr. Biddle, an observation in February 2011 that Mathies was “not very symptomatic.” AR 854. In the same sentence, Dr. Biddle noted that Mathies “does require a large amount of medication for rate control.” *Id.*

The ALJ then acknowledged that Mathies had not “achieved full resolution of his atrial fibrillation” but indicated that the evidence shows that he has “reached some level of control.” AR 18. The ALJ also referenced evidence indicating that Mathies’s symptoms of fatigue and shortness of breath were attributable, at least in part, to obesity and sleep apnea. *Id.* She noted that a CPAP device had been prescribed to assist with sleep apnea but that Mathies did not use that device regularly. *Id.*

The ALJ next summarized Dr. Hoffman's and Dr. Biddle's respective opinions, noting that if she were to adopt their assessments of Mathies's limitations, a finding of "disabled" would be required. AR 20. However, she found the opinions to be of "minimal probative value" and deemed each worthy of only "little weight." *Id.* The ALJ stated that the evidence of record, including each doctor's own treating notes, "fails to substantiate either of their assessments." *Id.* She also found that "other medical sources have more adequately defended contrary opinions." *Id.*

By way of further explanation, the ALJ stated that Mathies saw Dr. Biddle on only two occasions since September 2010. AR 20. She indicated that after one of those visits (in February 2011), Dr. Biddle "voiced little concern for his heart condition." AR 20 (citing AR 854-56). She then reported that Mathies did not seek Dr. Biddle again until December 2011, at which time he again found Mathies's cardiac condition to be stable. AR 21 (citing AR 1727-28).

As for Dr. Hoffman, the ALJ stated that he last saw Mathies in May 2012 and, at that time, found Mathies's cardiac condition to be stable, recommended no changes to medications and advised Mathies to return for a follow-up examination in a year. *Id.* Again, however, the ALJ misinterpreted the evidence. The record the ALJ referenced was actually written by Dr. Biddle, not Dr. Hoffman. AR 1747-48. The record contains evidence that Dr. Hoffman saw Mathies as late as November 2012, for continued treatment of pain in his back and feet. AR 1774.

The ALJ then contrasted the opinions of Dr. Hoffman and Dr. Biddle with other evidence. She discussed a report prepared on August 2, 2011, by Rose Mary Mason, M.D. a consultative examiner. According to the ALJ, Dr. Mason's report contained "few signs consistent with debilitation impairment or that would otherwise be expected to accommodate the limitations as asserted by the claimant's treating sources." AR 21. The ALJ acknowledged that Dr. Mason "did not offer an opinion on the claimant's capacity for work," but construed her report as showing "a lack of disabling impairment." *Id.*

The ALJ next noted that Mathies's orthopedic surgeon, Roy Abraham, M.D., saw Hoffman in March 2012 and listed his work status as "Full Work." AR 21 (citing AR 1733). The record at issue shows that the purpose of the examination was to address a complaint of left foot pain. AR 1733. Dr. Abraham concluded that Mathies had a healed fracture of the fifth toe on that foot. *Id.*

Finally, the ALJ discussed the testimony of the medical expert, Howard McClure, Jr., M.D. Dr. McClure testified that he is a "semi-retired internist" and had reviewed most (but not all) of Mathies's medical records. AR 51-52. Mathies's counsel indicated that the medical evidence that had been recently added to the record (marked as Exhibit 39F) was mostly cumulative. *Id.* Dr. McClure then opined that as of June 1, 2010, the alleged onset date, Mathies had a "light RFC with postural at occasional [sic]." *Id.* Dr. McClure stated that the same RFC applied as of February 2, 2011, the date SSA had previously determined Mathies to be disabled. *Id.* According to Dr. McClure, a "light" RFC means Mathies could sit for six hours during an eight-hour workday, stand for six hours during that workday, walk for two hours at a time, lift and carry 10 pounds frequently and lift and carry 20 pounds occasionally. AR 56. He further testified that Mathies had no limitations on such activities as reaching overhead, reaching in all directions, handling, fingering, pushing, pulling, etc. AR 56-57. However, he stated that Mathies was limited to some extent with regard to climbing stairs and ropes, balancing, stooping, kneeling, crouching and crawling. AR 57-58.

The ALJ found that Dr. McClure's opinions were entitled to "the greatest weight" because (a) they were based on "a complete review" of the record, (b) he has expertise in cardiology and (c) his experience as a consultant for SSA "affords him additional perspective in the laws and regulations by which the Administration is bound by in evaluating disability." AR 21.

Next, the ALJ discussed and discredited SSA's prior finding that Mathies became disabled on February 2, 2011. AR 22. The ALJ criticized a state agency consultant, Laura Griffith, D.O, for giving "moderate" weight to Dr. Biddle's opinions. *Id.* (citing

AR 1686-93). The ALJ further noted that other consultants had rated Mathies to be capable of light exertional work. *Id.* As such, the ALJ concluded that the prior finding of disability was not supported by the record. AR 22-23.

c. Analysis

As noted above, “[t]he opinion of a treating physician is accorded special deference under the social security regulations” and is “normally entitled to great weight.” *Vossen v. Astrue*, 612 F.3d 1011, 1017 (8th Cir. 2010) (quoting *Prosch v. Apfel*, 201 F.3d 1010, 1012 (8th Cir. 2000)). The issue here is whether the ALJ provided good reasons for discrediting the opinions of two treating physicians (Dr. Hoffman and Dr. Biddle) and instead giving great weight to the opinion of a consulting source (Dr. McClure) who did not examine Mathies. I find, with little difficulty, that the answer is “no.”

In discounting Dr. Hoffman’s and Dr. Biddle’s opinions, the ALJ stated that their treatment notes failed to substantiate the limitations described in their opinions. AR 20. As described earlier, however, it is apparent that the ALJ misinterpreted portions of the relevant records. In stating that the record is “essentially silent” about back pain between December 2008 and April 2011, the ALJ ignored evidence that Mathies went to Dr. Hoffman in December 2010, complained of chronic back pain and requested medication. AR 805. This request is significant because Mathies had previously declined Dr. Hoffman’s offer to prescribe pain medication. AR 814. Moreover, as I have noted, the ALJ’s discussion of the evidence repeatedly attributed various comments and findings to the wrong physician, casting serious doubt on whether she had a meaningful understanding of the record. As the Eighth Circuit Court of Appeals has stated: “While a ‘deficiency in opinion-writing is not a sufficient reason to set aside an ALJ’s finding where the deficiency [has] no practical effect on the outcome of the case,’ inaccuracies, incomplete analyses, and unresolved conflicts of evidence can serve as a basis for remand.” *Draper v. Barnhart*, 425 F.3d 1127, 1130 (8th Cir. 2005) (quoting *Reeder v.*

Apfel, 214 F.3d 984, 988 (8th Cir. 2000), and *Boyd v. Sullivan*, 960 F.2d 733, 736 (8th Cir. 1992)).

Moreover, the medical evidence casts doubt on the ALJ's conclusion that Dr. Hoffman's and Dr. Biddle's extensive treatment notes fail to substantiate their opinions. Dr. Hoffman stated his findings were based on the presence of uncontrolled atrial fibrillation on multiple occasions with tachycardia, fatigue, palpitations, shortness of breath with exertion, low back pain, neck pain, left ankle pain, and numbness and tingling of the feet. AR 1542, 1709. These conditions are described in his contemporaneous treatment notes. Meanwhile, Dr. Biddle stated that his opinions were based on clinical evidence of shortness of breath, fatigue, and palpitations, as well as diagnostic EKG testing that documented atrial fibrillation, despite numerous previous attempts at ablation AR 1533-34. Again, Dr. Biddle's treatment notes document the presence of these conditions. I find that the ALJ did not provide an adequate explanation for rejecting the opinions of these two treating sources.

Nor did the ALJ provide an adequate explanation for favoring the opinion of Dr. McClure, who did not examine Mathies, over the opinions of treating physicians. The ALJ found Dr. McClure to be more credible because (a) he reviewed the medical evidence, (b) he has "expertise in cardiology" and (c) he has experience as a consultant for SSA on disability claims. AR 21. These are not "good" reasons. Presumably, all non-examining medical sources review the medical evidence in the course of forming an opinion.² The fact that Dr. McClure did so here does not evaluate his status beyond that of any other non-examining medical consultant. Moreover, the record does not support the ALJ's reliance on Dr. McClure's "expertise in cardiology." As noted above, he described himself as a "semi-retired internist," not a cardiologist. AR 51. His curriculum vitae, which is part of the record, indicates that he completed a one-year

² See, e.g., 20 C.F.R. § 404.1615(b) (disability determinations made by state agency consultants must be based on "the medical and nonmedical evidence in [the agency's] files").

cardiology fellowship in 1962 but does not reflect that he became a board-certified cardiologist or otherwise practiced in that field. AR 174-75.³

Finally, while Dr. McClure apparently has experience serving as a medical expert for SSA (*see* AR 174), the Commissioner's regulations do not list such experience as a factor that an ALJ may consider in giving weight to a medical opinion. *See* 20 C.F.R. §404.1527(c)(2)-(6). The fact that a consulting medical source happens to provide opinions to SSA on a regular basis does not constitute a good reason for giving more weight to that source's opinion than to the opinion of a treating source. If anything, as noted above, the regulations make it clear that medical sources who have an actual treating relationship with the claimant are usually more persuasive than those who are simply hired to look at records and write reports. *See* 20 C.F.R. § 404.1527(c)(2).

In short, the ALJ's weighting of the various medical opinions is not supported by substantial evidence in the record as a whole. The ALJ acknowledged that if controlling weight is given to either Dr. Hoffman's or Dr. Biddle's opinions, then Mathies must be found to be disabled. AR 20. Unfortunately, the ALJ then undertook an error-ridden analysis that fails to provide good reasons for discrediting the opinions of two treating physicians while giving "great weight" to the opinion of a non-examining source. Normally, the opinion of a non-examining sources does not constitute substantial evidence. *Shontos v. Barnhart*, 328 F.3d 418, 427 (8th Cir. 2003). This does not mean the opinion of a non-examining source is automatically entitled to less weight than that of a treating source. *Willcockson v. Astrue*, 540 F.3d 878, 880 (8th Cir. 2008). However, if an ALJ is going to discredit treating source opinions and instead give greater weight to the opinion of a non-examining source, the ALJ must provide good reasons, supported by substantial evidence, justifying that outcome. That did not happen here.

³ While I mean absolutely no disrespect to Dr. McClure, it appears that he has not engaged in the active practice of medicine since 1995. AR 174. I find it rather astounding that the ALJ, without providing a compelling explanation, elected to favor his opinion as a non-examining source over those of two practicing physicians who have long treatment relationships with Mathies.

As such, I must recommend remand with directions that the ALJ reconsider the medical opinions and provide good reasons, supported by substantial evidence, for the weight given to each.⁴

B. Credibility

In the alternative, Mathies argues that the ALJ's evaluation of his credibility is not supported by substantial evidence. The ALJ found that Mathies exaggerated the extent of his symptoms and limitations, noting that he alleged "completely disabling symptoms and limitations" that go beyond those described by his own physicians. AR 23. Mathies contends that the ALJ failed to consider all of the relevant factors and, in particular, failed to take the combination of all impairments into account when assessing his credibility.

To determine a claimant's credibility, the ALJ must consider:

- (1) the claimant's daily activities;
- (2) the duration, intensity, and frequency of pain;
- (3) the precipitating and aggravating factors;
- (4) the dosage, effectiveness, and side effects of medication; and
- (5) any functional restrictions.

Polaski v. Heckler, 739 F.2d 1320, 1322 (8th Cir. 1984); *see also* 20 C.F.R. § 1529(c)(3). "Other relevant factors include the claimant's relevant work history, and the absence of objective medical evidence to support the complaints." *Mouser v. Astrue*, 545 F.3d 634, 638 (8th Cir. 2008) (quoting *Wheeler v. Apfel*, 224 F.3d 891, 895 (8th Cir. 2000)).

⁴ I recommend remand, rather than a reversal for an award of benefits, because I am unable to conclude that the record "overwhelmingly supports" a finding of disability. *See Buckner v. Apfel*, 213 F.3d 1006, 1011 (8th Cir. 2000). It is certainly possible that a denial of benefits could be supported by substantial evidence in the record as a whole, even when the record is analyzed properly.

While an ALJ may not discount a claimant's subjective complaints solely because they are unsupported by objective medical evidence, the lack of such evidence is a factor the ALJ may consider. *Halverson v. Astrue*, 600 F.3d 922, 931-32 (8th Cir. 2010); *Ford v. Astrue*, 518 F.3d 979, 982 (8th Cir. 2008). A claimant's credibility is "primarily for the ALJ to decide, not the courts." *Pearsall v. Massanari*, 274 F.3d 1211, 1218 (8th Cir. 2001). Thus, 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). An ALJ may discount a claimant's subjective complaints if there are inconsistencies in the record as a whole. *Id.*

Here, the ALJ referenced the relevant factors and provided an explanation for her decision to discredit Mathies's subjective allegations. AR 15-16, 23. Having carefully reviewed the ALJ's explanation, I find it to be supported by substantial evidence. Thus, I would not recommend remand based solely on the ALJ's credibility assessment. However, because I have found it necessary to recommend remand to revisit the weight given to various medical opinions, I will further recommend that the ALJ be directed to consider what impact, if any, this re-weighting has on the analysis of Mathies's credibility. For example, if controlling weight (or, at least, more weight) is given to the treating source opinions, it is possible that the ALJ's assessment of Mathies's credibility may change.

VI. CONCLUSION

After a thorough review of the entire record and in accordance with the standard of review I must follow, I RESPECTFULLY RECOMMEND that the Commissioner's determination that Mathies was not disabled be **reversed and remanded** for further proceedings consistent with this Report and Recommendation and that judgment be entered against the Commissioner and in favor of Mathies. I further recommend that on remand, the ALJ be directed to reconsider the weights given to the medical opinions of

record, including but not limited to those of the treating sources (Dr. Hoffman and Dr. Biddle) and the medical expert (Dr. McClure), and to provide good reasons, supported by substantial evidence, for the weight given to each opinion. The ALJ should then consider what effect, if any, this reconsideration has on the remainder of the disability evaluation process (including the assessment of Mathies's credibility).

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

IT IS SO ORDERED.

DATED this 9th day of December, 2014.



LEONARD T. STRAND
UNITED STATES MAGISTRATE JUDGE