No. _____

IN THE
Supreme Court of the United States

_____

BRYAN D. COLLINS,
Petitioner,

v.

NANCY A. BERRYHILL,
Acting Commissioner of the Social Security Administration,
Respondent.

_____

On Petition for a Writ of Certiorari
To the United States Court of Appeals
For the Seventh Circuit

_____

PETITION FOR A WRIT OF CERTIORARI

_____

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QUESTIONS PRESENTED

When determining the weight given to the medical opinion of a treating doctor who has stated that an applicant for social security benefits on the basis of disability is disabled, an ALJ must look at the treatment records of that treating doctor. 20 C.F.R. § 416.927(c)(2). The determination of the weight given to a medical opinion of a treating doctor is a finding of fact which must be supported by substantial evidence. See 42 U.S.C. § 405(g). A reviewing court applies a harmless error standard to the review of agency errors in administrative determinations.

The questions presented are:

1. What is the standard for assessing harmless error when a treating doctor has provided a form medical opinion statement that an applicant for social security benefits is disabled, but the treatment records of that doctor are obviously missing at the time of the ALJ hearing, and the ALJ decision discounts that doctor's opinion and finds the applicant not disabled without first obtaining and looking at the treatment records of that doctor?
2. In assessing harmless error, can a reviewing court, after obtaining and reviewing a treating doctor's treatment records which were missing at the time of the ALJ determination, re-weigh the medical opinion of that treating doctor in light of the new records without running afoul of the "*Chenery* doctrine," which provides that reviewing courts must judge the

propriety of administrative action solely by the grounds invoked by the agency? *Sec. & Exch. Comm'n v. Chenery Corp.*, 332 U.S. 194, 196, 67 S.Ct. 1575, 91 L.Ed. 1995 (1947).

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PETITION FOR A WRIT OF CERTIORARI

Bryan D. Collins petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Seventh Circuit.

OPINION BELOW

The decision of the Seventh Circuit (Pet. App. 2a) is unreported (7th Cir. 2018). The decision of the district court (Pet. App. 9a) is unreported.

JURISDICTION

The district court had jurisdiction over this case pursuant to 42 U.S.C. § 405(g). The judgment of the Seventh Circuit was entered on August 9, 2018, and the Petitioner's Petition for Rehearing was denied on September 24, 2018. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

42 U.S.C. § 405(g) states:

> The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive.

20 C.F.R. § 416.927(c)(2) states:

> 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.

20 C.F.R. § 416.927(c)(2)(ii) states:

> Generally, the more knowledge a treating source has about your impairment(s) the more weight we will give to the source's medical opinion. We will look at the treatment the source has provided and at the kinds and extent of examinations and testing the source has performed or ordered from specialists and independent laboratories.

STATEMENT OF THE CASE

A. Statutory and Regulatory Framework

When a person's treating doctor provides a medical opinion to the Social Security Administration ("SSA") that the person is disabled, this is often the most powerful evidence that a person can marshal to support their claim for disability benefits. The SSA is required to systematically weigh the medical opinion of a treating doctor. 20 CFR § 416.927(c)(2). This is important because, for the majority of disability claimants, the SSA disability determination process is not so much based on the medical conditions a person has, but rather on the unique functional limitations that a person has as a result of their medical conditions, after "step three" of the "sequential evaluation process". 20 C.F.R. § 416.920(a)(4); 20 CFR § 416.945. *See* Soc. Sec. Admin., SSA Pub. No. 13- 11826, *Annual Statistical Report on the Social Security Disability Insurance Program*, 2016 tbl. 65 (Oct. 2017) (finding that from 1999 to 2015, that consistently over 50% of all medical based denials of benefits were based on a "residual functional capacity" assessment that the applicant could return to past work or do other types of work) (hereinafter "SSA Data"), http://www.ssa.gov/policy/docs/statcomps/di_asr/2016/di_asr16.pdf.

The Social Security Administration employs the five-step "Sequential Evaluation Process" for assessing disability. 20 C.F.R. § 416.920(a)(4). At step one, if a person

is engaging in substantial gainful work activity, they will be found not disabled. 20 C.F.R. § 416.920(a)(4)(i). At step two, the SSA makes a "severity" and "duration" assessment, and if the SSA says that the person's medical conditions are not "severe", or if the medical conditions are expected to resolve within 12 months of the date of onset, then the person will be found not disabled. 20 C.F.R. § 416.920(a)(4)(ii). At step three, the SSA will assess whether the person's conditions "meets or equals" one of the listings in appendix 1 to subpart P of 20 CFR Part 404, and if so, the person is found disabled. 20 C.F.R. § 416.920(a)(4)(iii). If a person cannot be found disabled after step three, then a determination of the person's "residual functional capacity" must be made prior to steps 4 and 5. 20 C.F.R. § 416.920(a)(4)(iv)-(v). At step four, if the person's residual functional capacity allows them to return to past relevant work, then they will be found not disabled. 20 C.F.R. § 416.920(a)(4)(iv). At step five, if the person's residual functional capacity and their age, education, and work experience allow for an adjustment to other work, then they will be found not disabled. 20 C.F.R. § 416.920(a)(4)(v). Also at step five, if the person cannot make an adjustment to other work, then they will be found disabled. *Id.* If the SSA denies a person twice, and the person appeals, the claim proceeds to a hearing before an Administrative Law Judge ("ALJ"). The ALJ must make factual findings regarding the person's eligibility for disability benefits pursuant to the five-step process. 20 C.F.R. § 416.920(a)(4). Each of these findings must be supported by substantial evidence. See 42 U.S.C. § 405(g).

The determination of residual functional capacity prior to steps 4 and 5 is an inherently subjective inquiry based on vague regulations that the SSA has adopted in the attempt to codify what is necessary to prove a negative, namely, that a person is unable to work. 20 C.F.R. § 416.945. The SSA acknowledges that the expert in the best position to yield probative evidence regarding a person's functional limitations is the person's treating doctor. 20 C.F.R. § 416.927(c)(2). The process for weighing a medical opinion from a treating doctor states that the SSA will first consider whether the opinion can be given controlling weight, thereby automatically resulting in a finding of disability. *Id.* If controlling weight cannot be given, then the regulations provide that the SSA will weigh the opinion using the factors listed in 20 C.F.R. § 416.927(c)(2) – (6). Commenting on the importance of these regulations, the Second Circuit has stated:

> The requirement of reason-giving exists, in part, to let claimants understand the disposition of their cases, even—and perhaps especially—when those dispositions are unfavorable. A claimant like Snell, who knows that her physician has deemed her disabled, might be especially bewildered when told by an administrative bureaucracy that she is not, unless some reason for the agency's decision is supplied. See Jerry L. Mashaw, Due Process in the Administrative State 175-76 (1985). Snell is not entitled to have Dr. Cooley's opinion on the ultimate question of disability be treated as controlling, but she is entitled to be told why the Commissioner has decided—as under appropriate circumstances is his right—to disagree with Dr. Cooley. We therefore remand this case to the Appeals Council for a statement of the reasons on the basis of which Dr. Cooley's finding of disability was rejected.
>
> *Snell v. Apfel*, 177 F. 3d 128, 134 (2nd Cir. 1999)

Of critical importance in the weighing of a treating doctor's medical opinion, 20 C.F.R. § 416.927(c)(2)(ii) states, "We will look at the treatment the source has provided and at the kinds and extent of examinations and testing the source has

performed or ordered from specialists and independent laboratories." 20 C.F.R. § 416.927(c)(2)(ii). If the treatment records from the treating doctor providing the opinion are missing, this step cannot be completed, and an improper weighing of the opinion of the treating doctor has taken place. *Elder v. Astrue*, 529 F.3d 408, 415 (7th Cir. 2008)

In the face of such an erroneous decision by an administrative agency, the general rule of the Federal Statutes and the Supreme Court is to set aside that agency action. In *Sec. & Exch. Comm'n v. Chenery Corp.*, the Supreme Court has stated:

> [A] reviewing court, in dealing with a determination or judgment which an administrative agency alone is authorized to make, must judge the propriety of such action solely by the grounds invoked by the agency. If those grounds are inadequate or improper, the court is powerless to affirm the administrative action by substituting what it considers to be a more adequate or proper basis.
>
> *Sec. & Exch. Comm'n v. Chenery Corp.*, 332 U.S. 194, 196, 67 S.Ct. 1575, 91 L.Ed. 1995 (1947).

However, as various Courts of Appeals have acknowledged, the inquiry does not end there, but instead proceeds to an inquiry as to whether the error was harmless. On this question, the circuits are split.

In the Second Circuit case of *Snell*, supra, the court did not even consider harmless error issues when finding that remand was necessary in light of the failure to weigh the medical opinion of a treating doctor. *Snell*, 177 F. 3d at 134.

The Seventh Circuit has stated that "an omission is significant only if it is prejudicial." *Nelms v. Astrue*, 553 F.3d 1093, 1098 (7th Cir. 2009) (citing *Nelson v.*

Apfel, 131 F.3d 1228, 1235 (7th Cir. 1997)). Furthermore, also according to the Seventh Circuit, prejudice must be established by the disability claimant: "a claimant must set forth specific, relevant facts-such as medical evidence-that the ALJ did not consider." *Id.* Finally, "[i]f it is predictable *with great confidence* that the agency will reinstate its decision on remand because the decision is overwhelmingly supported by the record though the agency's original opinion failed to marshal that support, then remanding is a waste of time." *Spiva v. Astrue*, 628 F.3d 346, 353 (7th Cir. 2010)(emphasis added).

The Ninth Circuit has stated, "a reviewing court cannot consider [an] error harmless unless it can confidently conclude that no reasonable ALJ, when fully crediting the testimony, could have reached a different disability determination." *Marsh v. Colvin*, 792 F.3d 1170, 1173 (9th Cir. 2015) (citing *Stout v. Comm'r, Soc. Sec. Admin.*, 454 F.3d 1050, 1055-1056 (9th Cir. 2006)).

The most robust discussion of this issue was undertaken by the Sixth Circuit, which addressed the question in *Wilson v. Commissioner of Social Sec.*, 378 F.3d 541, 546-548 (6th Cir. 2004). In that case, the court concluded the following:

> Echoing the district court, the Commissioner contends that, assuming for argument's sake that the ALJ misread DeWys's opinion, this mistake qualifies as harmless error. The Commissioner asserts that the ALJ's rejection of DeWys's opinion is supported by substantial evidence, as the ALJ "could" have relied on evidence in the record — namely, Wilson's testimony and the opinions of two consulting physicians, which, according to the Commissioner, contradict DeWys's opinion — to reject the opinion.
>
> The argument is not persuasive in the context of this case. A court cannot excuse the denial of a mandatory procedural protection simply because, as the Commissioner urges, there is sufficient evidence in the record for the ALJ to discount the treating source's opinion and, thus, a different outcome on

remand is unlikely. "[A] procedural error is not made harmless simply because [the aggrieved party] appears to have had little chance of success on the merits anyway." *Mazaleski v. Treusdell*, 562 F.2d 701, 719 n. 41; see also *Ingalls Shipbuilding, Inc. v. Dir., Office of Workers' Comp. Programs*, 102 F.3d 1385, 1390 (5th Cir.1996). To hold otherwise, and to recognize substantial evidence as a defense to non-compliance with § 1527(d)(2), would afford the Commissioner the ability to violate the regulation with impunity and render the protections promised therein illusory. The general administrative law rule, after all, is for a reviewing court, in addition to whatever substantive factual or legal review is appropriate, to "set aside agency action ... found to be ... without observance of procedure required by law." Administrative Procedure Act, 5 U.S.C. § 706(2)(D) (2001).

Our conclusion is consistent with the statement in *Connor v. United States Civil Service Commission*, 721 F.2d 1054, 1056 (6th Cir.1983), that "an agency's violation of its procedural rules will not result in reversible error absent a showing that the claimant has been prejudiced on the merits or deprived of substantial rights because of the agency's procedural lapses" (emphasis added). A procedural right must generally be understood as "substantial" in the context of this statement when the regulation is intended to confer a procedural protection on the party invoking it. The Supreme Court has recognized the distinction between regulations "intended primarily to confer important procedural benefits upon individuals" and regulations "adopted for the orderly transaction of business before [the agency]." *Am. Farm Lines v. Black Ball Freight Serv.*, 397 U.S. 532, 538-39, 90 S.Ct. 1288, 25 L.Ed.2d 547 (1970) (internal quotation marks omitted). In the former case, the regulation bestows a "substantial right" on parties before the agency, and "it is incumbent upon agencies to follow their own procedures ... even where the internal procedures are possibly more rigorous than otherwise would be required." *Morton v. Ruiz*, 415 U.S. 199, 235, 94 S.Ct. 1055, 39 L.Ed.2d 270 (1974); see also *Vitarelli v. Seaton*, 359 U.S. 535, 540, 79 S.Ct. 968, 3 L.Ed.2d 1012 (1959); *United States ex rel. Accardi v. Shaughnessy*, 347 U.S. 260, 267, 74 S.Ct. 499, 98 L.Ed. 681 (1954). In contrast, in the case of procedural rules "adopted for the orderly transaction of business," an agency has the discretion "to relax or modify its procedural rules" and such action "is not reviewable except upon a showing of substantial prejudice to the complaining party." *Am. Farm Lines*, 397 U.S. at 539, 90 S.Ct. 1288 (quotation omitted). Section 1527(d)(2) falls in the former category, creating an important procedural safeguard for claimants for disability benefits. *Snell*, 177 F.3d at 134.

That is not to say that a violation of the procedural requirement of § 1527(d)(2) could never constitute harmless error. We do not decide the question of whether a de minimis violation may qualify as harmless error. For instance, if a treating source's opinion is so patently deficient that the

> Commissioner could not possibly credit it, a failure to observe § 1527(d)(2) may not warrant reversal. *Cf. NLRB v. Wyman-Gordon*, 394 U.S. 759, 766 n. 6, 89 S.Ct. 1426, 22 L.Ed.2d 709 (1969) (plurality opinion).

Wilson v. Commissioner of Social Sec., 378 F.3d at 546-548.

These three different conceptualizations, fielded from three separate Circuits, yield three different standards for determining harmless error, which can be categorized as follows: 1) the "prejudice" standard in the Seventh Circuit; 2) the "no reasonable ALJ" standard in the Ninth Circuit; and 3) the "patently deficient/impossible to credit" standard in the Sixth Circuit. Embedded within these different standards are two distinctly different burdens of proof to show harmless error. In the Sixth and Ninth Circuits, harmless error is considered an exception to the general rule of reversal due to an agency error, and this argument can be raised by the agency when an error is admitted. However, in the Seventh Circuit, the burden is on the person challenging the agency action to show that the error rose to a level of such significance as to be prejudicial. Furthermore, the Sixth and Ninth Circuits require the agency to meet the strongest possible burden of showing that reversal of the decision on remand is essentially impossible, using the words such as "no reasonable ALJ," *Marsh v. Colvin*, 792 F.3d at 1173, and "could not possibly credit," *Wilson*, 378 F.3d at 545. This is akin to holding the agency to a "beyond a reasonable doubt" standard. This is in contrast to the Seventh Circuit, where the burden is on the disability claimant to show the error was prejudicial, by producing "specific, relevant facts". *Nelms*, 553 F.3d at 1098. This is similar to the substantial evidence rule articulated in *Richardson v. Perales*, where an agency

decision is supported by "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales*, 402 US 389, 401 (1971) (citing *Consolidated Edison Co. v. NLRB*, 305 U. S. 197, 229 (1938)). The Seventh Circuit standard is essentially what was argued by the SSA to the Sixth Circuit in *Wilson*, and which the Sixth Circuit handily and specifically rejected. *Wilson*, 378 F.3d at 545.

The Seventh Circuit standard is a slippery slope to requiring that, even in the face of a violation of the agency's procedures in place to protect a disability claimant, the claimant must convince the reviewing court that they should find the claimant disabled right then and there, based on a fact-specific inquiry outside of agency procedures, and contrary to the principals of the *Chenery* doctrine. See *Nelms*, 553 F.3d at 1098; *Chenery*, 332 U.S. at 196. Unsurprisingly, Mr. Collins' case also raises the issue of when a reviewing court's assessment of harmless error might run afoul of the "*Chenery* doctrine." *Chenery*, 332 U.S. at 196. The *Chenery* doctrine is inextricably linked with harmless error analysis when it comes to judicial review of administrative agency decisions. The court in *Chenery* stated that a reviewing court may only affirm agency action on "the grounds invoked by the agency." *Id.* Virtually every case discussing harmless error in the context of judicial review of an administrative agency decision discusses *Chenery*. The Seventh Circuit itself has stated that, "the government's brief and oral argument … seem determined to dissolve the *Chenery* doctrine in an acid of harmless error." *Spiva*, 628 F.3d at 353. It is predictable, then, that the Seventh Circuit will

continue to run afoul of the *Chenery* doctrine, given the "prejudice" standard for evaluating harmless error, which invites a reviewing court to step into the shoes of the SSA ALJ. *Id.*

B. Procedural Background

Mr. Collins initially applied for Supplemental Security Income ("SSI") benefits on April 27, 2012, was denied initially on September 5, 2012, and denied upon reconsideration on March 15, 2013. Pet. App. 30a. Following Mr. Collins' request for a hearing before an ALJ, a hearing was held on January 21, 2015. Pet. App. 30a. At the hearing, Mr. Collins was represented by a different attorney than his present attorney. Pet. App. 30a.

At the hearing on January 21, 2015, Mr. Collins presented evidence and testimony which supported his allegation that he is disabled due to degenerative disc disease, deep vein thrombosis, depression, and anxiety. Pet. App. 32a. His primary care physician, Christopher Weber, M.D., of Sixteenth Street Community Health Centers, completed a medical source statement that indicated Mr. Collins was incapable of even sedentary work. Pet App. 57a-58a. Mr. Collins testified that Dr. Weber was his previous primary care provider, and that he saw him every two weeks. Pet App. 59a-60a. For unknown reasons, neither Mr. Collins' previous attorney representative, nor the ALJ, saw fit to request copies of Mr. Collins' records from Sixteenth Street Community Health Centers.

Following the hearing, the ALJ Decision gave little weight to the medical source statement of Dr. Weber, and the ALJ found that Mr. Collins would be able to do at

least one of the four jobs listed by the vocational expert ("VE") at the sedentary level. Pet App. 43a and Pet. App. 46a. Thus Mr. Collins was found not disabled. Pet. App. 47a.

Following the hearing, Mr. Collins filed a Pro Se request for Appeals Council review of this case. The Appeals Council denied that request on June 4, 2016. Pet. App. 53a. On August 8, 2016, Mr. Collins filed a Pro Se Complaint with the United States District Court for the Eastern District of Wisconsin. On September 8, 2017, the undersigned filed a Notice of Appearance on behalf of Mr. Collins in the District Court action. The undersigned reviewed Mr. Collins' file and discovered the records from the Sixteenth Street Community Health Centers had not been requested, then requested and submitted those records to the District Court. The decision of the Social Security Administration was affirmed by the District Court's Decision dated August 22, 2017.

Upon further judicial review of the ALJ Decision, the Seventh Circuit found that omission of Dr. Weber's records was non-prejudicial, applying the *Nelms* standard. Pet. App. 6a; *Nelms*, 553 F.3d at 1098. The court ruled, contrary to the requirement of *Elder*, supra, that the ALJ did not have to have the treatment records of Dr. Weber in order to properly weigh his medical opinion. Pet. App. 6a; *Elder*, 529 F.3d at 415. The court then proceeded to look at Dr. Weber's treatment records, weighed them, and concluded that they were insignificant and their omission was not prejudicial, which was something the ALJ had not done, and was therefore in direct violation of the *Chenery* doctrine. Pet. App. 6a; *Chenery*, 332 U.S. at 196. Mr.

Collins filed a Petition for Rehearing, on the grounds that the court had not properly applied the regulatory requirements, namely, the requirement that an ALJ must look at treatment records prior to weighing the medical opinion; further, Mr. Collins' petition for rehearing pointed out that the court could not provide post-hoc rationalizations regarding treatment records that the ALJ did not have. Nonetheless, the Petition for Rehearing was denied without further comment by the Seventh Circuit. Pet. App. 1a.

C. Legal Argument

Under the standards for evaluation of harmless error in the Ninth Circuits, judicial review of the ALJ Decision regarding Mr. Collins' disability would have resulted in a remand, since it cannot be established, when fully crediting Dr. Weber's testimony, that no reasonable ALJ would find Mr. Collins disabled. See, e.g., *Marsh*, 792 F.3d at 1173. In fact, fully crediting Dr. Weber's statements would invariably lead to a finding of disability. *Id.*

Under the Sixth Circuit standards for evaluating harmless error, judicial review of the ALJ Decision would likely have resulted in a remand, since the Commissioner would have to show that the treating source opinion was so patently deficient that the Commissioner could not possibly credit it. *Wilson*, 378 F.3d at 545. Such a showing could not be made, and never has been made, regarding Dr. Weber's medical opinion. *Id.* In fact, the *Wilson* court dealt with the exact same issue regarding weighing a treating source opinion, and had very strong words about the need for remand, even in spite of any perceived weakness in the claim, given the

important procedural protections in place in favor of disability claimants when it comes to the medical opinions of treating doctors. *Id.*

Under the Seventh Circuit standard, the burden of proving prejudice was placed on Mr. Collins, who argued that the missing records constituted a significant omission that was prejudicial to his claim for benefits. Pet App. 6a. Mr. Collins argued prejudice based on the fact that the treatment records were required in order to properly weigh the medical opinion of Dr. Weber pursuant to the Social Security regulations. However, the Seventh Circuit ruled that there was no prejudice.

First, the court specifically ruled that the ALJ was not required to even look at Dr. Weber's treatment records before weighing the medical opinion, in direct contradiction of the Seventh Circuit's prior ruling in *Elder,* and the rulings of other circuits. *Elder,* 529 F.3d at 415; *Wilson*, 378 F.3d at 546-547; *Snell,* 177 F.3d at 134; *Schaal v. Apfel*, 134 F.3d 496, 504 (2nd Cir. 1998).

Then, the court dove into an impermissible re-weighing of the medical opinion of Mr. Collins' treating doctor. Pet App 5a. The court took note of the newly submitted medical records (which the ALJ did not have at the time of the decision) and evaluated the medical opinion in light of those records. Pet App 5a. The court made comments discounting the medical opinion in spite of the newly obtained record. Pet App 5a. The Seventh Circuit went too far when it acknowledged the ALJ had not weighed Dr. Weber's medical opinion in light of Dr. Weber's treatment records and then completed that step for the ALJ. Pet. App. 5a. Such an action

cannot be labeled as anything other than affirming agency action on grounds other than "the grounds invoked by the agency." *Chenery*, 332 U.S. at 196.

The nexus of these two issues was discussed by the Second Circuit in *Schaal v. Apfel*, 134 F.3d 496, 504 (2nd Cir. 1998), where it was stated:

> Thus, under either rule, the ALJ's decision appears tainted by legal error. That is, his analysis seems flawed under the old treating physician rule in that it apparently fails to assign extra weight to the treating physician's opinion, and flawed under the 1991 Regulations as well in that the ALJ failed to consider all of the factors cited in the regulations.
>
> In light of these circumstances, we cannot be certain whether or not the Commissioner's ultimate conclusion that plaintiff was not disabled is supported by substantial evidence. "Where there is a reasonable basis for doubt whether the ALJ applied correct legal principles, application of the substantial evidence standard to uphold a finding of no disability creates an unacceptable risk that a claimant will be deprived of the right to have her disability determination made according to the correct legal principles." *Johnson v. Bowen,* 817 F.2d 983, 986 (2d Cir.1987). Where application of the correct legal standard could lead to only one conclusion, we need not remand. *Id.* However, on this record, we cannot say with certainty what weight should be assigned, pursuant to the 1991 Regulations, to the opinion of plaintiff's treating physician, or whether further clarification of the record with these regulations in mind might alter the weighing of the evidence. It is for the SSA, and not this court, to weigh the conflicting evidence in the record. *See Miller v. Chater,* 99 F.3d 972, 978 (10th Cir.1996) (an "appeals court does not reweigh the evidence in social security cases").
>
> *Schaal,* 134 F.3d at 504.

Mr. Collins' case tracks precisely the facts discussed in Schaal, "in that the ALJ failed to consider all of the factors cited in the regulations." *Id.* In such a situation, "It is for the SSA, and not this court, to weigh the conflicting evidence in the record." *Id.*

Thus, this case presents an opportunity to resolve the split in the Circuits regarding what standard should be applied to assess harmless error. This case also calls out for the Supreme Court to enforce the long-standing precedent of *Chenery*.

The petition for certiorari should be granted.

REASONS FOR GRANTING THE WRIT

I. THERE IS A CONFLICT OF AUTHORITY ON THE FIRST QUESTION PRESENTED.

The split between the circuits in evaluating harmless error is clearly discernible in this case. The Sixth Circuit case of *Wilson* distills the issue to a clear conflict between the SSA arguing that error is harmless if an ALJ could still find the person not disabled, as opposed to the standard that the court adopted, which requires that the SSA show that a finding of disability would be impossible. *Wilson*, 378 F.3d at 546-548. The Seventh Circuit rule falls well short of the Sixth Circuit standard, and even invites the courts to step into the shoes of the ALJ to determine if there is prejudice due to the error, while placing the burden on the disability claimant to prove prejudice. *Nelms*, 553 F.3d at 1098. As illustrated by Mr. Collins' case, the harmless error standard imposed by the Seventh Circuit is much more burdensome on the person than the standard in the Second, Sixth, and Ninth Circuits. Because of the volume of disability claims decided by Social Security Administration, and because of the volume of work that disability appeals create for the federal courts, it is judicially efficient to resolve this split now and set a standard for the courts. See SSA Data, supra.

II. THE CASE PRESENTS AN IMPORTANT & RECURRING ISSUE THAT WARRANTS THIS COURT'S REVIEW.

A person applying for Supplemental Security Income on the basis of disability is virtually always in dire straits. The fair evaluation of their disability claim can often mean the difference between housing or homelessness, dignity or destitution, and often, life or death in the most literal sense. Almost anyone who has worked on disability claims can tell a heart-wrenching story of a client who died homeless and destitute after being denied by, or while waiting for, a disability determination from the Social Security Administration because their advocate could not do enough to prevent such a tragic outcome. When multiplied by the millions of applications filed for disability benefits each year, it is sadly, tragically, and shamefully unsurprising that the Social Security Administration recently stated to the Washington Post that over 10,000 people died in fiscal 2017 while waiting for a disability determination from the Social Security Administration. *See* Washington Post article *597 days. And still waiting.* dated 11/20/2017, https://www.washingtonpost.com/sf/local/2017/11/20/10000-people-died-waiting-for-a-disability-decision-in-the-past-year-will-he-be next/?noredirect=on&utm_term=.7f674e15a308. As articulately stated in *Snell*, "A claimant like Snell, who knows that her physician has deemed her disabled, might be especially bewildered when told by an administrative bureaucracy that she is not, unless some reason for the agency's decision is supplied." *Snell,* 177 F. 3d at 134. What Mr. Collins is asking for in this case is a basic adherence to, and respect for, the procedures mandated for evaluation of his

treating doctor's opinion that he is disabled, in a decision that will have a tremendous effect on his life.

III. THIS CASE PRESENTS A UNIQUE OPPORTUNITY TO RESOLVE THIS CONFLICT.

This case presents a unique opportunity to resolve the conflicted circuits because it is a unique case. Not often does an ALJ make an error of failing to fully develop the record, especially when the missing records in question are from a treating doctor who has provided a medical opinion. Furthermore, this case is being brought from the Seventh Circuit, where the harmless error rule is particularly disadvantageous to disability claimants. It is unlikely that a challenge to the issue would arise out of the Sixth or Ninth Circuits.

IV. THE SEVENTH CIRCUIT'S DECISION WAS INCORRECT AND GOES AGAINST SUPREME COURT PRECEDENT.

The Seventh Circuit decision in this case goes directly against Supreme Court precedent in *Chenery*, and even goes against the Seventh Circuit's prior ruling in *Elder*. *Chenery*, 332 U.S. at 196; *Elder,* 529 F.3d at 415. The case of Mr. Collins begs for the Supreme Court to intervene to uphold its own precedent.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX

Appendix A

Case: 17-3189 Document: 36 Filed: 09/24/2018 Pages: 1

United States Court of Appeals

For the Seventh Circuit
Chicago, Illinois 60604

September 24, 2018

Before

DIANE S. SYKES, *Circuit Judge*

DAVID F. HAMILTON, *Circuit Judge*

MICHAEL B. BRENNAN, *Circuit Judge*

No. 17-3189

BRYAN D. COLLINS,
Plaintiff-Appellant,

v.

NANCY A. BERRYHILL,
Acting Commissioner of Social Security,
Defendant-Appellee.

Appeal from the
United States District Court
for the Eastern District of Wisconsin.

No. 16-CV-1044

David E. Jones,
Magistrate Judge.

ORDER

On consideration of the petition for rehearing filed by Plaintiff-Appellant on September 17, 2018, all of the judges on the original panel have voted to deny rehearing.

Accordingly, the petition for rehearing is **DENIED**.

Appendix B

Case: 17-3189 Document: 31 Filed: 08/09/2018 Pages: 6

United States Court of Appeals

For the Seventh Circuit
Chicago, Illinois 60604

Argued July 6, 2018
Decided August 9, 2018

Before

DIANE S. SYKES, *Circuit Judge*

DAVID F. HAMILTON, *Circuit Judge*

MICHAEL B. BRENNAN, *Circuit Judge*

No. 17-3189

BRYAN D. COLLINS,
Plaintiff-Appellant,

v.

NANCY A. BERRYHILL,
Acting Commissioner of Social Security,
Defendant-Appellee.

Appeal from the United States District Court for the Eastern District of Wisconsin.

No. 16-CV-1044

David E. Jones,
Magistrate Judge.

ORDER

Bryan Collins applied for supplemental security income from the Social Security Administration based on back pain, deep vein thrombosis, depression, and anxiety. An administrative law judge ("ALJ") found that Collins was exaggerating his symptoms, that the medical evidence did not support his claim, and that he could perform sedentary work with some restrictions. Because substantial evidence supports the ALJ's decision, we affirm the judgment.

Collins applied for benefits at age 42, alleging an onset date in April 2012. He had completed one year of college, and his only full-time employment was a year spent as an iron metalworker from 2006 to 2007. He identified several impairments that

prevented him from working: back pain resulting from an old gunshot wound; pain in his feet, left leg, and right hip, all of which he associated with a history of blood clots; depression; and anxiety. (Because Collins does not dispute the ALJ's conclusions regarding his psychological conditions, we recount only the medical evidence relating to his physical conditions.)

In July 2012, Dr. Mohammad Fareed performed a consultative exam at the request of the state agency and found few limitations. Collins reported severe back pain stemming from being assaulted and shot sometime in the early 1990s. Dr. Fareed found tenderness in Collins's spine and limited range of motion, though he wrote that Collins appeared "comfortable without any acute distress." X-rays showed degenerative disc disease in Collins's spine.

A year later Collins was seen by an internist, Dr. Christopher Weber who, after one examination, opined that Collins had extreme functional limitations. Dr. Weber diagnosed depression, chronic pain, "AC separation" (Collins's shoulder dislocation following a car accident), and sciatica. He concluded that Collins could walk less than a block, sit for only 20 minutes, stand for only 45 minutes, would need "constant" unscheduled breaks during a workday, and could never lift even 10 pounds. Dr. Weber did not support his opinion with any explanation, test results, or treatment notes.

In March 2014, Collins sought treatment for leg pain from another internist, Michael Weinstein who diagnosed a clot and prescribed a blood thinner. X-rays of Collins's spine and hip taken two months later showed degenerative disc disease and mild loss of disc space in Collins's spine.

Several months later Collins sought treatment from family-medicine practitioner Umar Shad for his leg and back pain. Dr. Shad advised Collins to continue taking blood thinners, and to rest and apply ice and heat to his back. Dr. Shad also referred Collins to orthopedic and pain-management specialists.

In 2013 and 2014, Collins frequently visited emergency rooms, his primary method of treatment and his source for painkiller and blood-thinner prescriptions. None of the medical examiners ever found that he had severe mobility issues, though he occasionally had swelling and pitting (indentation caused by fluid buildup) in his legs.

At a hearing before an ALJ in early 2015, Collins, represented by counsel, testified to extreme functional limitations. He said his back pain was constant and his leg hurt when he walked. Collins twice tried to work but was unable to do so because of his back pain. He explained that he could walk only three or four blocks, sit and stand only five to ten minutes each, and lift about eight pounds. He lived with his mother but was unable to help much around the house. When asked to identify his primary-care physician, Collins said he saw Dr. Weber every two weeks.

A vocational expert ("VE") testified that Collins could find work in the national economy despite having some limitations. When asked if there were jobs for someone who could perform only sedentary work and who needed to change from sitting to standing at will, the VE replied such a person could work as a food preparer, lobby attendant, assembly worker, or office helper. The VE clarified that lobby attendant is considered light work but could be done either sitting or standing and with no lifting. The ALJ asked the VE whether her opinion was otherwise consistent with the Dictionary of Occupational Titles ("DOT"), and the VE said that it was, except that the DOT did not cover a worker's need to change between sitting and standing. The VE based her testimony that a lobby attendant could change positions on published research and 30 years' experience placing people with disabilities in jobs.

The ALJ applied the familiar five-step analysis, *see* 20 C.F.R. § 416.920(a), and concluded that Collins was not disabled. Collins does not dispute the results of the first three steps. He takes issue with the ALJ's conclusion at step four that he could perform unskilled, sedentary work with some further restrictions, including the need to change from sitting to standing at will. The ALJ gave little weight to Dr. Weber's opinion that Collins had extreme functional limitations. The ALJ found the opinion conclusory, that Dr. Weber wrote it after only his first visit with Collins, and that it was inconsistent with the mild abnormalities revealed by objective imaging and other physical exams performed by the consultative examiner, the hospital physicians, and Drs. Shad and Weinstein. The ALJ also found that Collins's testimony regarding the extent of his pain was inconsistent with the conservative course of treatment he received, as well as the findings by objective medical tests and physical examiners. Nonetheless, because of Collins' pain and reduced range of motion, the ALJ restricted him to sedentary work.

At step five, the ALJ determined that a significant number of jobs existed that Collins could perform; the ALJ relied on the VE's testimony that Collins could find sedentary work as a food preparer, lobby attendant, assembler, or office helper. The ALJ noted that the DOT does not match the VE's testimony that "lobby attendant" is

sedentary work and that all four jobs allow for change between sitting and standing positions at will. But the ALJ credited the VE's conclusions based on her stated reliance on published research and her 30 years' experience.

The Appeals Council denied review, and so the ALJ's decision stands as the final decision of the agency. *Scrogham v. Colvin*, 765 F.3d 685, 695 (7th Cir. 2014).

Collins, represented by different counsel, appealed to the district court and submitted new medical evidence, arguing that the ALJ had failed to develop the record by not ordering further medical records from Dr. Weber's practice. To show prejudice, Collins submitted records from Dr. Weber's practice covering four visits that he had with three providers between May and December 2013. Without these records, Collins maintained, the ALJ could not have properly considered the factors established by 20 C.F.R. § 416.927(c) for evaluating a treating physician's opinion.* The magistrate judge, presiding with the parties' consent, rejected Collins's argument, concluding that no evidentiary gap needed to be filled and the missing records did not demonstrate symptoms or findings more severe than those found by the ALJ.

On appeal, Collins maintains that the ALJ failed in his duty to develop the record because he did not collect other medical records from Dr. Weber's office. He cites *Nelms v. Astrue*, 553 F.3d 1093, 1098–99 (7th Cir. 2009), in which this court concluded that an ALJ's failure to fairly and fully develop the record is error, as long as the applicant can show prejudice. Collins argues he was prejudiced by the ALJ's failure to collect these other medical records because they were necessary to properly evaluate the opinion of his treating physician, Dr. Weber, in accordance with the factors listed by 20 C.F.R. § 416.927(c), including the length of the treatment relationship and frequency of examination. Collins contends the ALJ should have known this evidence existed because he listed Dr. Weber and another provider from Dr. Weber's practice on a form statement of recent medical treatments and testified at his hearing that he saw Dr. Weber, his primary care physician, every two weeks.

An ALJ has an independent duty to develop the record fully and fairly. *See* 20 C.F.R. § 416.912(b); *Thomas v. Colvin*, 745 F.3d 802, 807 (7th Cir. 2014). This duty is not eliminated when a claimant has counsel, as the Commissioner concedes. *See Smith*

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* Collins also included medical records from other providers, some of which are already in the record and some of which postdate the ALJ's decision.

v. Apfel, 231 F.3d 433, 437 (7th Cir. 2000). *But see Nelms*, 553 F.3d at 1098 ("This duty is enhanced when a claimant appears without counsel....").

Even if we assume that the ALJ breached this duty, we agree with the Commissioner that the failure to collect the supplemental records from Dr. Weber's practice did not prejudice Collins. In weighing a treating physician's opinion, an ALJ must consider the factors found in 20 C.F.R. § 416.927(c), but need only "minimally articulate" his reasoning; the ALJ need not explicitly discuss and weigh each factor. *Elder v. Astrue*, 529 F.3d 408, 415 (7th Cir. 2008). The ALJ satisfied this standard in this case by considering the length of the treatment relationship and frequency of examination; the supportability of Dr. Weber's opinion; and the consistency of the opinion with other medical evidence in the record. *See* 20 C.F.R. § 416.927(c)(2)(i), (3)–(4), (d). Nothing in the supplemental records undercuts the ALJ's consideration of those factors. Dr. Weber acknowledged in his opinion that he had examined Collins only one time. That he later saw Collins once more, or that Collins occasionally saw other physicians in the practice, does not affect the weight that the ALJ should have given an opinion based on only one examination. Moreover, the findings in the supplemental records are all consistent with the other medical evidence in the record: subjective reports of pain, and only insignificant objective findings. The ALJ reviewed other medical records—including ones that predated and postdated Dr. Weber's opinion—and these contained remarkably similar findings. For these reasons, these supplemental records simply do not constitute a significant omission.

Collins next argues that the ALJ did not properly resolve the "apparent" conflicts between the VE's testimony and the DOT as required by SSR 00–4p, 2000 WL 1898704, at *4. *See Overman v. Astrue*, 546 F.3d 456, 464 (7th Cir. 2008). Collins contends that the four sedentary jobs identified by the VE are listed as light work in the DOT and that the DOT does not specify that any of them can be performed while changing positions at will.

We agree with Collins that there is an "apparent" and unresolved conflict between the VE's testimony that Collins could find sedentary work as a food preparer, lobby attendant, assembler, or office helper, versus the DOT, which classifies food preparer and office helper as light work. *See* U.S. DEP'T. OF LABOR, DICTIONARY OF OCCUPATIONAL TITLES, 65038A, 239.567-010, https://occupationalinfo.org/. Although the conflict was not identified at the hearing, it would have been obvious had the ALJ checked the DOT and it was incumbent on the ALJ to resolve it. *See Pearson v. Colvin*, 810 F.3d 204, 205–06, 210–11 (4th Cir. 2015) (conflict was "apparent," even though not

identified at hearing, when VE testified claimant could perform job despite not being able to reach but DOT classified job as requiring reaching).

But this oversight is not fatal because the DOT lists assembler positions that are sedentary, *see, e.g.*, DOT 739.687-066, 715.687-114, 739.684-094, and the VE estimated that 55,000 of these jobs allow changing position at will. (A.R. 83.) That is a significant number of jobs in the national economy, so any error would be harmless. *See Brown v. Colvin*, 845 F.3d 247, 255 (7th Cir. 2016) (failure to resolve apparent conflict not fatal when at least 5303 other appropriate jobs exist in the national economy).

Finally, Collins challenges the VE's testimony by questioning whether those sedentary assembler jobs in fact allow a worker to change from sitting to standing at will. But Collins forfeited that challenge by not objecting at the hearing which, in any event, is not in "apparent" conflict with the DOT. *See Brown*, 845 F.3d at 254. Because the DOT does not specify whether jobs allow changing from sitting to standing, the VE's testimony supplemented the DOT and did not conflict with it. *See id.*

AFFIRMED

UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

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FINAL JUDGMENT

August 9, 2018

Before: DIANE S. SYKES, *Circuit Judge*

DAVID F. HAMILTON, *Circuit Judge*

MICHAEL B. BRENNAN, *Circuit Judge*

No. 17-3189	BRYAN D. COLLINS, Plaintiff - Appellant v. NANCY A. BERRYHILL, Acting Commissioner of Social Security, Defendant - Appellee
Originating Case Information:	
District Court No: 2:16-cv-01044-DEJ Eastern District of Wisconsin Magistrate Judge David E. Jones	

The judgment of the District Court is **AFFIRMED**, with costs, in accordance with the decision of this court entered on this date.

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WISCONSIN

BRYAN DERRELL COLLINS,

Plaintiff,

v. **Case No. 16-CV-1044**

COMMISSIONER OF THE SOCIAL SECURITY ADMINISTRATION,

Defendant.

DECISION AND ORDER

Bryan Derrell Collins alleges disability based on a musculoskeletal issues, blood clots, depression, and anxiety. After the Social Security Administration denied his application for disability benefits, Mr. Collins requested and received a hearing before an administrative law judge. The ALJ determined that Mr. Collins remained capable of working notwithstanding his impairments. Mr. Collins now seeks judicial review of that decision.

Mr. Collins argues that the ALJ failed to fully and fairly develop the record, erred in weighing the opinion of his primary care physician, and improperly relied on flawed testimony from a vocational expert. The Commissioner contends that the ALJ did not commit an error of law in reaching his decision and that the decision is otherwise supported by substantial evidence. For the reasons that follow, the Court finds that the ALJ did not commit reversible error when he determined that Mr.

Collins is not disabled. The Court therefore will affirm the Commissioner's decision denying Mr. Collins disability benefits.

I. Background

Bryan Derrell Collins was born on December 24, 1969. Transcript 60, ECF No. 14-2–14-10. As of January 2015, Mr. Collins was separated from his wife and living with his mother in Milwaukee. Tr. 60–61. He did not have any income, but he received monthly food stamps. Tr. 62. Mr. Collins possesses a GED, and he previously worked as a metal grinder, a foundry pourer, and a sand molder. Tr. 60, 62–65. He was laid off in 2007, however, after being injured at work. Tr. 63–64. Mr. Collins has not worked since then due to his physical and mental impairments. *See* Tr. 64, 180.

Mr. Collins suffers from a number of impairments, including chronic depression; serious back problems; acute, severe pain in his leg, foot, and right hip; swollen legs; anxiety; and schizophrenia. Tr. 180. In Spring 2012, he filed an application for supplemental security income, alleging disability as of August 1, 2007. Tr. 162–66. After the Social Security Administration denied his application initially, Tr. 88–99, and upon reconsideration, Tr. 100–11, Mr. Collins requested and received a hearing before an administrative law judge, Tr. 116–25, 129–54, 156. Mr. Collins was represented by counsel at the hearing on January 21, 2015; the ALJ heard testimony from Mr. Collins and Ms. Winkman, a vocational expert. *See* Tr. 55–87.[1]

[1] At the hearing, Mr. Collins amended his alleged onset date to April 27, 2012. *See* Tr. 59.

The ALJ followed the five-step sequential evaluation process and on March 4, 2015, he issued a decision unfavorable to Mr. Collins. Tr. 11–36. The ALJ determined that (1) Mr. Collins did not engage in substantial gainful activity since his amended alleged onset date; (2) Mr. Collins suffered from four "severe" impairments: degenerative disc disease, deep vein thrombosis, depression, and anxiety; (3) Mr. Collins did not suffer from an impairment or combination of impairments that met or medically equaled the severity of a presumptively disabling impairment; Mr. Collins had the residual functional capacity to perform sedentary work with certain physical and mental restrictions; (4) Mr. Collins was not able to perform his past relevant work as an iron metal worker, a foundry pourer, or a hand molder; and (5) Mr. Collins remained capable of performing the requirements of various unskilled, sedentary occupations. *See* Tr. 14–31. Based on those findings, the ALJ concluded that Mr. Collins was not disabled.

Thereafter, the Appeals Council denied Mr. Collins's request for review, Tr. 1–5, making the ALJ's decision the final decision of the Commissioner of Social Security, *see Loveless v. Colvin*, 810 F.3d 502, 506 (7th Cir. 2016).

Mr. Collins filed this action on August 8, 2016, seeking judicial review of the Commissioner's decision under 42 U.S.C. § 405(g). Complaint, ECF No. 1. The matter was reassigned to this Court after both parties consented to magistrate judge jurisdiction. *See* Consent to Proceed Before a Magistrate Judge, ECF Nos. 6 & 11 (citing 28 U.S.C. § 636(c) and Fed. R. Civ. P. 73(b)). It is now fully briefed and ready for disposition. *See* Plaintiff's Brief, ECF No. 16; Defendant's Memorandum in

Support of the Commissioner's Decision, ECF No. 21; and Plaintiff's Reply Brief, ECF No. 22.

II. Standard of Review

"Judicial review of Administration decisions under the Social Security Act is governed by 42 U.S.C. § 405(g)." *Allord v. Astrue*, 631 F.3d 411, 415 (7th Cir. 2011) (citing *Jones v. Astrue*, 623 F.3d 1155, 1160 (7th Cir. 2010)). Pursuant to sentence four of § 405(g), federal courts have the power to affirm, reverse, or modify the Commissioner's decision, with or without remanding the matter for a rehearing.

Judicial review is limited to determining whether the Commissioner's final decision is supported by "substantial evidence." *See* § 405(g); *see also Moore v. Colvin*, 743 F.3d 1118, 1120–21 (7th Cir. 2014). Substantial evidence is "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Moore*, 743 F.3d at 1120–21 (quoting *Richardson v. Perales*, 402 U.S. 389, 401 (1971)). The ALJ's decision must be affirmed if it is supported by substantial evidence, "even if an alternative position is also supported by substantial evidence." *Scheck v. Barnhart*, 357 F.3d 697, 699 (7th Cir. 2004).

In reviewing the record, this Court "may not re-weigh the evidence or substitute its judgment for that of the ALJ." *Skarbek v. Barnhart*, 390 F.3d 500, 503 (7th Cir. 2004). Rather, the Court must determine whether the ALJ built an "accurate and logical bridge between the evidence and the result to afford the claimant meaningful judicial review of the administrative findings." *Beardsley v. Colvin*, 758 F.3d 834, 837 (7th Cir. 2014); *Moore*, 743 F.3d at 1121. The ALJ's

decision must be reversed "[i]f the evidence does not support the conclusion." *Beardsley*, 758 F.3d at 837. Likewise, the Court must remand "[a] decision that lacks adequate discussion of the issues." *Moore*, 743 F.3d at 1121.

Reversal also is warranted "if the ALJ committed an error of law or if the ALJ based the decision on serious factual mistakes or omissions," regardless of whether the decision is otherwise supported by substantial evidence. *Beardsley*, 758 F.3d at 837 (citations omitted). An ALJ commits an error of law if his decision "fails to comply with the Commissioner's regulations and rulings." *Brown v. Barnhart*, 298 F. Supp. 2d 773, 779 (E.D. Wis. 2004). Reversal is not required, however, if the error is harmless. *See, e.g.*, *Farrell v. Astrue*, 692 F.3d 767, 773 (7th Cir. 2012); *see also Keys v. Barnhart*, 347 F.3d 990, 994–95 (7th Cir. 2003).

III. Discussion

Mr. Collins asks the Court to vacate the ALJ's decision and remand the matter to the Commissioner for a new hearing. *See* Pl.'s Br. 9; Pl.'s Reply 7.

A. Legal framework

Under the Social Security Act, a person is "disabled" only if he is unable "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 has lasted or can be expected to last for a continuous period of not less than 12 months." *See* 42 U.S.C. §§ 416(i)(1) and 423(d)(1)(A). The disability must be sufficiently severe that the claimant cannot return to his prior job and is not capable of

engaging in any other substantial gainful work that exists in the national economy. § 423(d)(2)(A).

In determining whether a person is disabled, the SSA must follow a five-step sequential evaluation process, asking, in order: (1) whether the claimant has engaged in substantial gainful activity since his alleged onset of disability; (2) whether the claimant suffers from a medically determinable impairment or combination of impairments that is severe; (3) whether the claimant's impairment or combination of impairments is of a severity to meet or medically equal the criteria of any impairment listed in the SSA regulations as presumptively disabling; (4) whether the claimant's RFC leaves him unable to perform the requirements of his past relevant work; and (5) whether the claimant is unable to perform any other work. *See* 20 C.F.R. § 416.920(a)(4).

An affirmative answer at either step three or step five leads to a finding that the claimant is disabled. *Briscoe*, 425 F.3d at 352. "The claimant bears the burden of proof at steps one through four." *Id.* Once the claimant shows an inability to perform past work, the burden then shifts to the Commissioner to show the claimant's ability to engage in other work existing in significant numbers in the national economy. *Id.*

B. Legal analysis

Mr. Collins argues that the ALJ failed to fully and fairly develop of record, erred in weighing the medical opinion of his primary care provider, failed to properly investigate and resolve conflicts between the vocational expert's testimony

and the *Dictionary of Occupational Titles*, and improperly relied on flawed vocational expert testimony. The Court will address each argument in turn.

1. Whether the ALJ failed to fully and fairly develop the record

From May 2013 until May 2015, Mr. Collins received care at the Sixteenth Street Community Health Center in Milwaukee for his various health issues, including depression, lower back pain, and deep vein thrombosis. *See* Appendix to Pl.'s Br. 2–20, 48–50, ECF No. 16-1. He was seen by four different medical professionals: Angie B. Montoto, P.A.; Maritza Laguna, M.D.; Christopher E. Weber, M.D.; and Stephanie J. Dominguez, P.A. App. 2–26. On August 21, 2013, Dr. Weber completed a residual functional capacity questionnaire concerning Mr. Collins's impairments. *See* Tr. 307–08. The questionnaire is part of the administrative record, but the other medical records are not, even though Mr. Collins specifically listed treatment by PA Montoto and Dr. Weber on his Recent Medical Treatment form, *see* Tr. 238, and testified at the hearing that Dr. Weber had been his primary care physician, *see* Tr. 75–76.

Mr. Collins argues that the ALJ failed to fully and fairly develop the record when he neglected to request and obtain the medical records from the Sixteenth Street clinic. *See* Pl.'s Br. 2–3; Pl.'s Reply 1–5. According to Mr. Collins, these "obviously" missing records "are vital to assessing the substantial evidence and clinical findings that support the disability determination," given that they were from his primary care provider. Pl.'s Br. 3; Pl.'s Reply 3–4.

ALJs have "a basic obligation . . . to develop a full and fair record," *Smith v. Sec'y of Health, Educ. & Welfare*, 587 F.2d 857, 860 (7th Cir. 1978), but reviewing courts "generally uphold[] the reasoned judgment of the Commissioner on how much evidence to gather," *Nelms v. Astrue*, 553 F.3d 1093, 1098 (7th Cir. 2009) (citing *Luna v. Shalala*, 22 F.3d 687, 692 (7th Cir. 1994); *Binion v. Shalala*, 13 F.3d 243, 246 (7th Cir. 1994)). When a claimant is represented by counsel at the administrative level, the ALJ is "'entitled to assume'" that he "is making his 'strongest case for benefits.'" *Wilkins v. Barnhart*, 69 F. App'x 775, 781 (7th Cir. 2003) (quoting *Glenn v. Sec'y of Health & Human Servs.*, 814 F.2d 387, 391 (7th Cir. 1987))." "Moreover, a significant omission is usually required before [reviewing courts] will find that the [Commissioner] failed to assist *pro se* claimants in developing the record fully and fairly." *Luna*, 22 F.3d at 692 (citing *Thompson v. Sullivan*, 933 F.2d 581, 586–88 (7th Cir. 1991)). "In other words, the omission must be prejudicial." *Nelson v. Apfel*, 131 F.3d 1228, 1235 (7th Cir. 1997).

A review of all the evidence demonstrates that the ALJ met his burden to develop the record in this case. In determining that Mr. Collins is not disabled, the ALJ discussed in detail Mr. Collins's subjective complaints and reported activities, the objective medical evidence—including multiple emergency room visits—and all of the opinion evidence contained in the record. *See* Tr. 20–28. Notably, Mr. Collins does not argue that this information was insufficient for the ALJ to assess his RFC and make a disability determination.

Furthermore, the Court is not convinced that the ALJ was obligated to obtain the medical records from the Sixteenth Street clinic. Mr. Collins was represented by counsel during his administrative proceedings (albeit not the same attorney he has now). That lawyer did not submit the Sixteenth Street records, and there is no evidence that he asked the ALJ to obtain them. At the administrative hearing, Mr. Collins's lawyer did not object to the admission of the exhibits listed by the ALJ. Tr. 57–58. He also never mentioned the missing records, *see* Tr. 55–87, or attempted to supplement the record following the hearing. Mr. Collins has not identified any case within the Seventh Circuit ordering remand for failure to develop the record under circumstances similar to those here.

Even if the Court were to find that the ALJ erred in failing to obtain the Sixteenth Street records, a remand would not be appropriate in this case. Mr. Collins's current lawyer obtained the missing records and attached them to his brief, but he has not attempted to explain how this additional evidence could have supported his disability claim. Rather, he asserts in conclusory fashion that the records are vital simply because they are from a primary care provider. Mr. Collins therefore has not demonstrated that he was prejudiced by the missing medical records. *See Martin v. Astrue*, 345 F. App'x 197, 202 (7th Cir. 2009) (declining to reverse despite missing medical records because the claimant did not attempt to explain "what additional information about his condition the ALJ would have uncovered" and "fail[ed] to explain how additional evidence could have led to a

finding of disability") (citing *Nelms*, 553 F.3d at 1098 & n.1; *Johnson v. Barnhart*, 449 F.3d 804, 808 (7th Cir. 2006); *Nelson*, 131 F.3d at 1236)).

In fairness to Mr. Collins's current lawyer, a prejudice argument would have been very difficult to construct based on the missing records. The Sixteenth Street records document five visits from May 17, 2013, until May 6, 2015—including a sixteen-month gap covering all of 2014—where Mr. Collins generally complained about lower back pain that sometimes radiated to his legs, shoulder pain following a car accident, and depressive feelings. *See* App. 2–26. Treatment providers assessed lumbago with sciatica, a sprained left shoulder, and moderately severe depression. The ALJ discussed those same impairments in detail, citing other treatment notes that were in the record and that encompassed the same time period. *See generally* Tr. 21–26. Accordingly, there was no evidentiary gap that needed to be filled. Nor did the missing records demonstrate symptoms or findings more severe than those found by the ALJ.

2. Whether the ALJ erred in weighing the opinion of Dr. Weber

Mr. Collins relatedly argues that the absence of the Sixteenth Street records precluded the ALJ from properly weighing Dr. Weber's opinion in accordance with social security regulations. *See* Pl.'s Br. 4–5 (citing 20 C.F.R. § 416.927(c)); Pl.'s Reply 5 (same). The Court respectfully disagrees.

Dr. Weber completed the RFC Questionnaire on August 21, 2013. *See* Tr. 307–08. He opined that Mr. Collins could sit for only twenty minutes at a time and zero total hours in a workday and could stand or walk for only forty-five minutes at

a time and zero total hours in a workday. Dr. Weber further opined that Mr. Collins would need to constantly take unscheduled breaks during the workday and would need a job that permitted him to shift positions at will. According to Dr. Weber, Mr. Collins could not lift and carry any objects in a competitive work environment, including those weighing less than ten pounds, and he would be excessively absent from work due to his impairments or treatments. Overall, Dr. Weber concluded that Mr. Collins was not physically capable of sustained employment.

The ALJ assigned "little weight" to Dr. Weber's opinions. *See* Tr. 27. He noted that Dr. Weber filled out the Questionnaire during his first visit with Mr. Collins and therefore "did not have the opportunity to consider the claimant's longitudinal functioning." Tr. 27. According to the ALJ, the mild abnormalities revealed by objective imaging and noted by examiners suggested functional abilities greater than those advocated by Dr. Weber. The ALJ also concluded that Dr. Weber's opinions were conclusory and inconsistent with Mr. Collins's self-reported activities.

Upon reviewing the record, the Court concludes that the ALJ provided "good reasons" for discounting Dr. Weber's opinions. *See* 20 C.F.R. § 416.927(c)(2); *Campbell v. Astrue*, 627 F.3d 299, 306 (7th Cir. 2010). As the ALJ correctly noted, Dr. Weber completed the Questionnaire after his first visit with Mr. Collins, and there is no evidence to suggest that Dr. Weber reviewed Mr. Collins's previous medical records. Moreover, the record supports the ALJ's determination that Mr. Collins's functional abilities were greater than those suggested by Dr. Weber. Although Mr. Collins complained about pain in his back, legs, and shoulder, the

treatment notes frequently show that he demonstrated a normal gait, normal muscle strength, adequate range of motion, and negative straight leg raises, and the objective imaging studies revealed only mild abnormalities. *See* Tr. 21–23 (citing, e.g., Tr. 287, 293–94, 310, 315, 333–34, 349, 354, 366, 372, 390, 395, 399, 445, 481–82). The ALJ reasonably accounted for Mr. Collins's physical deficiencies by restricting him to sedentary work with additional postural limitations. *See* Tr. 20. Mr. Collins does not challenge that RFC assessment.

Furthermore, the missing Sixteenth Street records actually support, rather than undermine, the reasons the ALJ provided for discounting Dr. Weber's opinions. Dr. Weber saw Mr. Collins only two times: August 21, 2013, and December 30, 2013. *See* App. 5–13. During that first visit, Mr. Collins complained about pain in both feet and his left arm, but he was not in acute distress, he did not have swelling or tenderness in his feet, his mood was non-depressed, and his affect was normal. App. 10–13. He did exhibit tenderness in his left shoulder, which he had hurt two months prior in a car accident. Mr. Collins complained about shortness of breath and back pain during the second visit. App. 5–9. The physical examination revealed the left shoulder deformity and tenderness in his left calf but otherwise normal findings. The other records from the Sixteenth Street clinic reveal similar findings. *See* App. 2–4 (tenderness in spine, negative straight leg raise, and limping), 14–26 (abnormalities in left shoulder; positive right straight leg raise;

tenderness in right buttocks, foot, and back; normal strength; and normal gait).[2] Accordingly, Dr. Weber's relationship with Mr. Collins was quite minimal, and his treatment notes do not reveal the significant functional limitations contained in his RFC Questionnaire.

3. Whether the ALJ failed to investigate and resolve conflicts between the vocational expert's testimony and the *DOT*

During the administrative hearing, the ALJ proposed a series of hypothetical questions to Ms. Winkman, the vocational expert. Ms. Winkman testified that a hypothetical individual with Mr. Collins's age, education, work experience, and RFC could work as a food preparer, a lobby attendant, an assembler, or an office helper. *See* Tr. 81–84. She identified the following number of positions at the unskilled, sedentary level in the United States: food preparer – 26,000; lobby attendant – 17,000; assembler – 130,000; and office helper – 99,000. Ms. Winkman testified that the same jobs would be available if the hypothetical person were further allowed to change positions at will between sitting and standing, except only 50,000 assembler jobs would remain with that restriction. Mr. Collins's lawyer at the administrative level declined to be provided with *DOT* numbers for those jobs.

Mr. Collins argues that this action must be reversed because the ALJ violated Social Security Ruling 00-4p. *See* Pl.'s Br. 5–8; Pl.'s Reply 5–6. SSR 00-4p "requires ALJs to investigate and resolve any apparent conflict between the VE's

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[2] The materials submitted by Mr. Collins reveal only three visits at the Sixteenth Street clinic with medical professionals aside from Dr. Weber (that is, five total visits over a two-year span), including the aforementioned sixteen-month gap in treatment and one visit that occurred after the ALJ issued his decision.

testimony and the *DOT*." *Weatherbee v. Astrue*, 649 F.3d 565, 570 (7th Cir. 2011) (citing SSR 00-4p, 2000 SSR LEXIS 8 (Dec. 4, 2000); *Overman v. Astrue*, 546 F.3d 456, 463 (7th Cir. 2008)). "A conflict is apparent if it is 'so obvious . . . that the ALJ should have picked up on [it] without any assistance.'" *Weatherbee*, 649 F.3d at 570 (quoting *Overman*, 546 F.3d at 463). When there is an apparent conflict, ALJs "must elicit a reasonable explanation for the conflict before relying on the VE . . . evidence to support a . . . decision about whether the claimant is disabled." SSR 00-4p, 2000 SSR LEXIS 8, at *4–5. ALJs must explain in their decisions how such conflicts were resolved. *Id.* at *9.

Mr. Collins identifies two "apparent conflicts" between Ms. Winkman's testimony and the *DOT*. *First*, Ms. Winkman testified that the four occupations are performed at the sedentary exertional level while the *DOT* describes them all as light work. The Commissioner concedes that two of the occupations identified by Ms. Winkman—food preparer and office helper—are considered light work in the *DOT*. *See* Def.'s Mem. 7. The ALJ never identified or resolved this conflict. The ALJ also arguably violated SSR 00-4p with respect to the lobby attendant occupation. Ms. Winkman explained that lobby attendant is listed in the *DOT* as a light occupation but can be done standing or sitting and without any lifting. *See* Tr. 83. It seems that such a conclusory explanation is not reasonable. *See* SSR 00-4p, 2000 SSR LEXIS 8, at 6–7 ("Although there may be a reason for classifying the exertional demands of an occupation (as generally performed) differently than the DOT (e.g., based on other reliable occupational information), the regulatory definitions of

exertional levels are controlling.").

The ALJ did not, however, violate SSR 00-4p concerning the assembler occupation. The *DOT* lists hundreds of assembler jobs, which range in exertional level from heavy (motorcycle assembler DOT 806.684-090) to medium (matchbook assembler DOT 649.685-074) to light (billiard-table assembler DOT 732.384-010) to sedentary (fishing-reel assembler DOT 732.684-062). It is apparent from her testimony that Ms. Winkman was referencing sedentary assembler positions when questioned by the ALJ. Ms. Winkman characterized the assembler job as being "independent at a bench," and the figures she provided pertained only to assembler positions at the unskilled, sedentary level. *See* Tr. 83. The fact that some assembler jobs "are beyond the capabilities of sedentary, non-skilled laborers is not, on its own, sufficient to establish an apparent conflict between the VE's testimony and the *DOT*." *See Weatherbee*, 649 F.3d at 572.

Second, Ms. Winkman acknowledged that the *DOT* does not address the need to alternate at will between sitting and standing. *See* Tr. 84. Ms. Winkman did not create a "conflict" within the meaning of SSR 00-4p simply by providing testimony on an issue that is not addressed in the *DOT*. Ms. Winkman did not identify an inconsistency regarding shifting positions; rather, she simply filled in an information gap. Moreover, to the extent that an apparent conflict did exist regarding the need to alternate between sitting and standing, the ALJ identified and resolved this conflict in compliance with SSR 00-4p. Ms. Winkman indicated that her testimony regarding this limitation was based on published research and

her thirty years of experience finding jobs for disabled individuals. *See* Tr. 84. The ALJ accepted this reasonable explanation. *See* Tr. 30.

Mr. Collins faults the ALJ for failing to explain how he resolved this "conflict," but he fails to articulate what more the ALJ could have (or should have) done. The ALJ identified an issue not addressed by the *DOT*; questioned the vocational expert about that issue; obtained from the vocational expert the basis for her testimony; and accepted the vocational expert's explanation as reasonable. This process comported with SSR 00-4p.

4. Whether the ALJ erroneously relied on flawed testimony from the vocational expert

Mr. Collins relatedly argues that the ALJ's step-five finding is not supported by substantial evidence because it was based on Ms. Winkman's "flawed" testimony. *See* Pl.'s Br. 8–9. The Court is not convinced.

At step five of the sequential evaluation process, the ALJ accepted Ms. Winkman's testimony concerning the types of occupations that Mr. Collins could perform and the availability of such work. *See* Tr. 29–30. The ALJ also accepted Ms. Winkman's explanation concerning the apparent inconsistencies between her testimony and the *DOT*. Ms. Winkman testified that there are 50,000 assembler jobs in the United States that are performed at the unskilled, sedentary level and that would allow a worker to change positions at will between sitting and standing. Thus, even putting aside the issues identified above concerning the food preparer, office helper, and lobby attendant occupations, substantial evidence supports the ALJ's finding that there are jobs that exist in significant numbers in the national

economy that Mr. Collins can perform despite his limitations. *See, e.g.*, *Liskowitz v. Astrue*, 559 F.3d 736, 743 (7th Cir. 2009) ("As few as 174 jobs has been held to be significant, and it appears to be well-established that 1,000 jobs is a significant number.") (citations omitted).

IV. Conclusion

For all the foregoing reasons, the Court finds that the ALJ did not err in failing to seek and obtain records from the Sixteenth Street clinic, in weighing Dr. Weber's medical opinion, in investigating and resolving conflicts between Ms. Winkman's testimony and the *DOT*, and in relying on Ms. Winkman's testimony at step five of the sequential evaluation process. The Court therefore will affirm the ALJ's decision denying Mr. Collins's claim for disability benefits.

NOW, THEREFORE, IT IS HEREBY ORDERED that the Commissioner's decision is **AFFIRMED**.

IT IS FURTHER ORDERED that this action is **DISMISSED**.

FINALLY, IT IS ORDERED that the Clerk of Court enter judgment accordingly.

Dated at Milwaukee, Wisconsin, this 22nd day of August, 2017.

BY THE COURT:

s/ David E. Jones
DAVID E. JONES
United States Magistrate Judge

United States District Court
Eastern District of Wisconsin

BRYAN DERRELL COLLINS,
Plaintiff,

JUDGMENT IN A CIVIL CASE

v.

Case No. 16-CV-1044

COMMISSIONER OF THE SOCIAL SECURITY ADMINISTRATION,
Defendant.

☐ **Jury Verdict.** This action came before the Court for a trial by jury. The issues have been tried, and the jury has rendered its verdict.

☒ **Decision by Court.** This action came before the Court for consideration.

IT IS HEREBY ORDERED AND ADJUDGED that the Commissioner's decision is **AFFIRMED**.

IT IS FURTHER ORDERED that this action be and hereby is **DISMISSED**.

Approved: *s/ David E. Jones*
DAVID E. JONES
United States Magistrate Judge

Dated at Milwaukee, Wisconsin, this 22nd day of August, 2017.

STEPHEN C. DRIES
Clerk of Court

s/Becky Ray
(By) Deputy Clerk

SOCIAL SECURITY ADMINISTRATION

Refer To: [redacted]

Office of Disability Adjudication and Review
SSA ODAR Hearing Ofc
Suite 300W
310 W. Wisconsin Ave.
Milwaukee, WI 53203

Date: March 4, 2015

Bryan Derrell Collins
Apt 101
1230 E Singer Circle
Milwaukee, WI 53212

Notice of Decision – Unfavorable

I carefully reviewed the facts of your case and made the enclosed decision. Please read this notice and my decision.

If You Disagree With My Decision

If you disagree with my decision, you may file an appeal with the Appeals Council.

How To File An Appeal

To file an appeal you or your representative must ask in writing that the Appeals Council review my decision. You may use our Request for Review form (HA-520) or write a letter. The form is available at www.socialsecurity.gov. Please put the Social Security number shown above on any appeal you file. If you need help, you may file in person at any Social Security or hearing office.

Please send your request to:

Appeals Council
Office of Disability Adjudication and Review
5107 Leesburg Pike
Falls Church, VA 22041-3255

Time Limit To File An Appeal

You must file your written appeal **within 60 days** of the date you get this notice. The Appeals Council assumes you got this notice 5 days after the date of the notice unless you show you did not get it within the 5-day period.

The Appeals Council will dismiss a late request unless you show you had a good reason for not

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filing it on time.

What Else You May Send Us

You or your representative may send us a written statement about your case. You may also send us new evidence. You should send your written statement and any new evidence **with your appeal**. Sending your written statement and any new evidence with your appeal may help us review your case sooner.

How An Appeal Works

The Appeals Council will consider your entire case. It will consider all of my decision, even the parts with which you agree. Review can make any part of my decision more or less favorable or unfavorable to you. The rules the Appeals Council uses are in the Code of Federal Regulations, Title 20, Chapter III, Part 416 (Subpart N).

The Appeals Council may:

- Deny your appeal,
- Return your case to me or another administrative law judge for a new decision,
- Issue its own decision, or
- Dismiss your case.

The Appeals Council will send you a notice telling you what it decides to do. If the Appeals Council denies your appeal, my decision will become the final decision.

The Appeals Council May Review My Decision On Its Own

The Appeals Council may review my decision even if you do not appeal. If the Appeals Council reviews your case on its own, it will send you a notice within 60 days of the date of this notice.

When There Is No Appeals Council Review

If you do not appeal and the Appeals Council does not review my decision on its own, my decision will become final. A final decision can be changed only under special circumstances. You will not have the right to Federal court review.

New Application

You have the right to file a new application at any time, but filing a new application is not the same as appealing this decision. If you disagree with my decision and you file a new application instead of appealing, you might lose some benefits or not qualify for benefits at all. If you disagree with my decision, you should file an appeal within 60 days.

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If You Have Any Questions

We invite you to visit our website located at www.socialsecurity.gov to find answers to general questions about social security. You may also call (800) 772-1213 with questions. If you are deaf or hard of hearing, please use our TTY number (800) 325-0778.

If you have any other questions, please call, write, or visit any Social Security office. Please have this notice and decision with you. The telephone number of the local office that serves your area is (877)405-7842. Its address is:

Social Security
1710 S 7th St
Suite 200
Milwaukee, WI 53204-3538

Brent C Bedwell
Administrative Law Judge

Enclosures:
Decision Rationale
Form HA-L39 (Exhibit List)

cc: Bradford D. Myler
Law Offices Of Brad D. Myler & Associates
P.O. Box 127
Lehi, UT 84043-0127

SOCIAL SECURITY ADMINISTRATION
Office of Disability Adjudication and Review

DECISION

IN THE CASE OF	**CLAIM FOR**
Bryan Derrell Collins (Claimant)	Supplemental Security Income
(Wage Earner)	[redacted] (Social Security Number)

JURISDICTION AND PROCEDURAL HISTORY

On April 27, 2012, the claimant protectively filed an application for supplemental security income, alleging disability beginning August 1, 2007 (Exhibit 2D). The claim was denied initially on September 5, 2012, and upon reconsideration on March 15, 2013. Thereafter, the claimant filed a written request for hearing on April 20, 2013 (20 CFR 416.1429 *et seq.*). The claimant appeared and testified at a hearing held on January 21, 2015, in Milwaukee, WI. Jacquelyn E. Wenkman, an impartial vocational expert, also appeared at the hearing. The claimant was represented at the hearing by attorney, Michael Ryan. At hearing, the claimant amended his alleged onset date to his application date, April 27, 2012, consistent with his filing date.

ISSUES

The issue is whether the claimant is disabled under section 1614(a)(3)(A) of the Social Security Act. Disability is defined as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment or combination of impairments that 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 12 months.

Although supplemental security income is not payable prior to the month following the month in which the application was filed (20 CFR 416.335), the undersigned has considered the complete medical history consistent with 20 CFR 416.912(d).

After careful consideration of all the evidence, the undersigned concludes the claimant has not been under a disability within the meaning of the Social Security Act since April 27, 2012, the date the application was filed.

APPLICABLE LAW

Under the authority of the Social Security Act, the Social Security Administration has established a five-step sequential evaluation process for determining whether an individual is disabled (20 CFR 416.920(a)). The steps are followed in order. If it is determined that the

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claimant is or is not disabled at a step of the evaluation process, the evaluation will not go on to the next step.

At step one, the undersigned must determine whether the claimant is engaging in substantial gainful activity (20 CFR 416.920(b)). Substantial gainful activity (SGA) is defined as work activity that is both substantial and gainful. "Substantial work activity" is work activity that involves doing significant physical or mental activities (20 CFR 416.972(a)). "Gainful work activity" is work that is usually done for pay or profit, whether or not a profit is realized (20 CFR 416.972(b)). Generally, if an individual has earnings from employment or self-employment above a specific level set out in the regulations, it is presumed that he has demonstrated the ability to engage in SGA (20 CFR 416.974 and 416.975). If an individual engages in SGA, he is not disabled regardless of how severe his physical or mental impairments are and regardless of his age, education, and work experience. If the individual is not engaging in SGA, the analysis proceeds to the second step.

At step two, the undersigned must determine whether the claimant has a medically determinable impairment that is "severe" or a combination of impairments that is "severe" (20 CFR 416.920(c)). An impairment or combination of impairments is "severe" within the meaning of the regulations if it significantly limits an individual's ability to perform basic work activities. An impairment or combination of impairments is "not severe" when medical and other evidence establish only a slight abnormality or a combination of slight abnormalities that would have no more than a minimal effect on an individual's ability to work (20 CFR 416.921; Social Security Rulings (SSRs) 85-28, 96-3p, and 96-4p). If the claimant does not have a severe medically determinable impairment or combination of impairments, he is not disabled. If the claimant has a severe impairment or combination of impairments, the analysis proceeds to the third step.

At step three, the undersigned must determine whether the claimant's impairment or combination of impairments is of a severity to meet or medically equal the criteria of an impairment listed in 20 CFR Part 404, Subpart P, Appendix 1 (20 CFR 416.920(d), 416.925, and 416.926). If the claimant's impairment or combination of impairments is of a severity to meet or medically equal the criteria of a listing and meets the duration requirement (20 CFR 416.909), the claimant is disabled. If it does not, the analysis proceeds to the next step.

Before considering step four of the sequential evaluation process, the undersigned must first determine the claimant's residual functional capacity (20 CFR 416.920(e)). An individual's residual functional capacity is his ability to do physical and mental work activities on a sustained basis despite limitations from his impairments. In making this finding, the undersigned must consider all of the claimant's impairments, including impairments that are not severe (20 CFR 416.920(e) and 416.945; SSR 96-8p).

Next, the undersigned must determine at step four whether the claimant has the residual functional capacity to perform the requirements of his past relevant work (20 CFR 416.920(f)). The term past relevant work means work performed (either as the claimant actually performed it or as it is generally performed in the national economy) within the last 15 years or 15 years prior to the date that disability must be established. In addition, the work must have lasted long enough for the claimant to learn to do the job and have been SGA (20 CFR 416.960(b) and

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416.965). If the claimant has the residual functional capacity to do his past relevant work, the claimant is not disabled. If the claimant is unable to do any past relevant work or does not have any past relevant work, the analysis proceeds to the fifth and last step.

At the last step of the sequential evaluation process (20 CFR 416.920(g)), the undersigned must determine whether the claimant is able to do any other work considering his residual functional capacity, age, education, and work experience. If the claimant is able to do other work, he is not disabled. If the claimant is not able to do other work and meets the duration requirement, he is disabled. Although the claimant generally continues to have the burden of proving disability at this step, a limited burden of going forward with the evidence shifts to the Social Security Administration. In order to support a finding that an individual is not disabled at this step, the Social Security Administration is responsible for providing evidence that demonstrates that other work exists in significant numbers in the national economy that the claimant can do, given the residual functional capacity, age, education, and work experience (20 CFR 416.912(g) and 416.960(c)).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

After careful consideration of the entire record, the undersigned makes the following findings:

1. The claimant has not engaged in substantial gainful activity since April 27, 2012, the application date (20 CFR 416.971 *et seq.*).

2. The claimant has the following severe impairments: degenerative disc disease, deep vein thrombosis, depression and anxiety (20 CFR 416.920(c)).

The claimant suffers from a back impairment and lower extremity vascular impairment. His degenerative disc disease and deep vein thrombosis have at least more than a minimal effect on his ability to do work-related activity and they thus are severe impairments. The undersigned acknowledges that different examiners offered various diagnoses to describe the claimant's back impairment and lower extremity vascular impairment. For purposes of this decision, the above-referenced severe impairments of degenerative disc disease and deep vein thrombosis encompass those various diagnoses.

The claimant also suffers from mental impairments. His depression and anxiety have at least more than a minimal effect on his ability to do work-related activity and they thus are severe impairments. The undersigned acknowledges that different examiners offered various diagnoses to describe the claimant's affective disorder and anxiety-related condition. For purposes of this decision, the above-referenced severe impairments of depression and anxiety encompass those various diagnoses. The undersigned also acknowledges that there are references in the record to other mental impairments, including substance abuse disorders and personality disorders. However, the claimant required treatment primarily for his depression and anxiety during the period relevant to this decision; his other mental impairments caused at most mild symptoms and required minimal treatment. As such, they are not severe impairments. Nonetheless, the undersigned considered all of the claimant's mental symptoms and limitations in Finding 4, below, regardless of their cause.

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There is also evidence of other physical impairments. However, the claimant's other physical impairments do not meet the criteria to qualify as severe impairments. In June of 2013, the claimant presented to the emergency room following a motor vehicle accident; he complained of left shoulder pain (Exhibit 14F, pp. 4-5). On examination, the claimant had marked pain with joint movement affecting the left clavicle and acromioclavicular joint; he was exquisitely tender to palpation over the left clavicle and acromioclavicular joint (Exhibit 14F, p. 6). X-rays of the left shoulder showed no evidence of fracture; they showed superior subluxation of the distal left clavicle with respect to the acromion process compatible with at least a partial acromioclavicular joint separation (Exhibit 14F, p. 9). The claimant did not require admission (Exhibit 14F, p. 8). The claimant required no significant ongoing treatment for his left shoulder injury. Moreover, as discussed in Finding 4, below, examiners did not note left upper extremity abnormalities on subsequent musculoskeletal examinations. The claimant's lack of ongoing treatment and the subsequent normal clinical findings with regard to the claimant's left upper extremity suggest that his left shoulder impairment did not have at least more than a minimal effect on his ability to do work-related activity for 12 months. As such, it is not a severe impairment.

In August of 2014, the claimant presented to the emergency room with complaints of head injury following an altercation (Exhibit 13F, p. 34). A neurological examination revealed no significant abnormalities, but the claimant had a laceration to his forehead (Exhibit 13F, p. 35). A CT of the head showed no intracranial hemorrhage, mass effect or evidence of acute ischemia (Exhibit 13F, p. 40). It revealed two small well-corticated defects extending through the entire thickness of the calvarium near the skull vertex that was possibly due to prior trauma, surgery or developmental variant (Exhibit 13F, p. 40). The claimant required no ongoing treatment for his head injury. The normal neurological findings and the claimant's need for no significant subsequent treatment suggest that his head injury did not result in a neurological impairment having at least more than a minimal effect on his ability to do work-related activity. Therefore, it is not a severe impairment.

As noted above, the claimant has a severe impairment of deep vein thrombosis. While he complained of occasional mild respiratory symptoms, the medical evidence suggests that the claimant's deep vein thrombosis did not cause a severe respiratory, pulmonary or other cardiovascular impairment. In February of 2014, the claimant presented to the emergency room with complaints of chest pain (Exhibit 13F, pp. 84 and 92). He acknowledged that he took some PCP recently (Exhibit 13F, p. 92). On examination, the claimant's lungs were clear and he had good peripheral pulses (Exhibit 13F, p. 92). A CT of the chest was negative, showing no pulmonary emboli (Exhibit 12F, p. 6). X-rays of the chest performed the same day showed no active cardiopulmonary disease (Exhibits 12F, p. 7 and 13F, p. 76). A treadmill stress echocardiogram did not reveal any dynamic ST or T wave changes; the stress echocardiogram images revealed normal augmentation of all left ventricular segments but poor visualization limited the evaluation of the anterior wall (Exhibit 12F, p. 8). There was note that the claimant had a very poor functional capacity level and could not obtain peak heart rate, thus significantly reducing the sensitivity of ischemia detection (Exhibit 12F, p. 8). The claimant received Ativan in the emergency room and he denied chest pain three hours later (Exhibit 13F, p. 92). The claimant required admission, but Michael G. Manske, M.D., discharged the claimant later that day noting that he was quite comfortable and did not have a myocardial infarction (Exhibit 13F,

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pp. 81 and 89). The relatively normal imaging and the claimant's quick improvement with medication suggest that his symptoms of chest pain were mild in nature and not caused by a severe underling impairment.

In June of 2014, the claimant presented to the emergency room with complaints of left lower extremity pain and low back pain and a cough (Exhibit 13F, pp. 51-52). On examination, he was in no acute respiratory distress and his breath sounds were normal (Exhibit 13F, p. 53). X-rays of the chest were stable and revealed no acute findings (Exhibit 13F, p. 59). The following month, the claimant returned to the emergency room with complaints of left leg pain (Exhibit 13F, pp. 42-43). On examination, the claimant was in no respiratory distress and his breath sounds were normal (Exhibit 13F, p. 44). Also in July of 2014, the claimant presented to Umar Shad, M.D., to establish care (Exhibit 15F, p. 1). On examination, the claimant's lungs were clear to auscultation bilaterally (Exhibit 15F, p. 2). In October of 2014, the claimant presented to the emergency room with complaints of upper respiratory symptoms (Exhibit 13F, p. 15). On examination, he was in no respiratory distress and he had normal breath sounds (Exhibit 13F, p. 17). X-rays of the chest were stable, showing no acute cardiopulmonary disease (Exhibit 13F, p. 26). In November of 2014, the claimant presented to the emergency room with complaints of left leg and calf pain (Exhibit 13F, p. 3). On examination, he was in no acute respiratory distress and he had normal breath sounds (Exhibit 13F, p. 3). The consistently stable and unremarkable imaging of the claimant's chest and consistently normal clinical respiratory findings, considered in combination with the objective findings noted during the claimant's February of 2014 pulmonary and cardiovascular workup, are consistent with at most minimal abnormalities. While the claimant's deep vein thrombosis is a severe impairment, this evidence suggests that his deep vein thrombosis does not result in a respiratory, pulmonary or other cardiovascular impairment that has at least more than a minimal effect on his ability to do work-related activity.

The undersigned acknowledges that there are references in the record to other relatively mild physical conditions, including elevated cholesterol, a left forearm stab wound, a laceration to his forehead and gastrointestinal issues (Exhibits 2F, 12F, 13F and 14F). These conditions resolved in less than 12 months with treatment, did not require any treatment and/or did not have at least more than a minimal effect on the claimant's ability to do work-related activity. Therefore, they are not severe impairments.

3. The claimant does not have an impairment or combination of impairments that meets or medically equals the severity of one of the listed impairments in 20 CFR Part 404, Subpart P, Appendix 1 (20 CFR 416.920(d), 416.925 and 416.926).

In making this finding, the undersigned considered the relevant Listings corresponding to the claimant's medically determinable impairments (see Sections 1.00, et seq., Musculoskeletal System – Adult; 3.00, et seq., Respiratory System – Adult; 4.00, et seq., Cardiovascular System – Adult; 5.00, et seq., Digestive System – Adult; 7.00, et seq., Hematological Disorders – Adult; 8.00, et seq., Skin Disorders – Adult and 11.00, et seq., Neurological – Adult). Despite the claimant's impairments, the medical evidence does not document listing-level severity, and no acceptable medical source has mentioned findings equivalent in severity to the criteria of any listed impairment, individually or in combination. While the claimant's degenerative disc disease and deep vein thrombosis are severe impairments, the objective findings and severity of

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the symptoms associated with those conditions do not rise to the level contemplated by the Listings. The undersigned discusses the claimant's severe impairments in detail in Finding 4, below. As discussed above, the claimant's other impairments do not even meet the low threshold to qualify as severe impairments. The symptoms associated with those impairments do not approach those contemplated by the Listings.

The severity of the claimant's mental impairments, considered singly and in combination, do not meet or medically equal the criteria of listings 12.04, 12.06, 12.08, and 12.09. In making this finding, the undersigned has considered whether the "paragraph B" criteria are satisfied. To satisfy the "paragraph B" criteria, the mental impairments must result in at least two of the following: marked restriction of activities of daily living; marked difficulties in maintaining social functioning; marked difficulties in maintaining concentration, persistence, or pace; or repeated episodes of decompensation, each of extended duration. A marked limitation means more than moderate but less than extreme. Repeated episodes of decompensation, each of extended duration, means three episodes within 1 year, or an average of once every 4 months, each lasting for at least 2 weeks.

In activities of daily living, the claimant has mild restriction. In social functioning, the claimant has mild difficulties. With regard to concentration, persistence or pace, the claimant has moderate difficulties. As for episodes of decompensation, the claimant has experienced no episodes of decompensation, which have been of extended duration. The undersigned discusses the justification for these conclusions in Finding 4, below.

Because the claimant's mental impairments do not cause at least two "marked" limitations or one "marked" limitation and "repeated" episodes of decompensation, each of extended duration, the "paragraph B" criteria are not satisfied.

The undersigned has also considered whether the "paragraph C" criteria are satisfied. In this case, the evidence fails to establish the presence of the "paragraph C" criteria. As discussed below, the record does not show that the claimant experienced repeated episodes of decompensation, each of an extended duration. Additionally, there is no evidence of a residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in environment would be predicted to cause the claimant to decompensate. Finally, the claimant is able to function outside a highly supportive living arrangement. Therefore, the "paragraph C" criteria are not satisfied.

The limitations identified in the "paragraph B" criteria are not a residual functional capacity assessment but are used to rate the severity of mental impairments at steps 2 and 3 of the sequential evaluation process. The mental residual functional capacity assessment used at steps 4 and 5 of the sequential evaluation process requires a more detailed assessment by itemizing various functions contained in the broad categories found in paragraph B of the adult mental disorders listings in 12.00 of the Listing of Impairments (SSR 96-8p). Therefore, the following residual functional capacity assessment reflects the degree of limitation the undersigned has found in the "paragraph B" mental function analysis.

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4. After careful consideration of the entire record, the undersigned finds that the claimant has the residual functional capacity to perform sedentary work as defined in 20 CFR 416.967(a) except he must be allowed to change positions between sitting and standing at will; he is limited to occasional stooping, crouching, kneeling, crawling and climbing of ramps and stairs; he cannot operate foot controls or climb ladders, ropes and scaffolds; he is limited to unskilled work; he is limited to jogs involving only occasional decision-making and changes in the work setting; and he will be off task up to ten percent of the workday, in addition to regularly scheduled breaks.

In making this finding, the undersigned has considered all symptoms and the extent to which these symptoms can reasonably be accepted as consistent with the objective medical evidence and other evidence, based on the requirements of 20 CFR 416.929 and SSRs 96-4p and 96-7p. The undersigned has also considered opinion evidence in accordance with the requirements of 20 CFR 416.927 and SSRs 96-2p, 96-5p, 96-6p and 06-3p.

In considering the claimant's symptoms, the undersigned must follow a two-step process in which it must first be determined whether there is an underlying medically determinable physical or mental impairment(s)--i.e., an impairment(s) that can be shown by medically acceptable clinical and laboratory diagnostic techniques--that could reasonably be expected to produce the claimant's pain or other symptoms.

Second, once an underlying physical or mental impairment(s) that could reasonably be expected to produce the claimant's pain or other symptoms has been shown, the undersigned must evaluate the intensity, persistence, and limiting effects of the claimant's symptoms to determine the extent to which they limit the claimant's functioning. For this purpose, whenever statements about the intensity, persistence, or functionally limiting effects of pain or other symptoms are not substantiated by objective medical evidence, the undersigned must make a finding on the credibility of the statements based on a consideration of the entire case record.

The claimant premised his application for supplemental security income on allegations of a back impairment; pain in his right hip, leg and foot; swelling in his legs; chronic depression and anxiety (Exhibit 2E, p. 2). He also noted that he experienced blood clots since 1989 (Exhibit 17E, p. 1). Since filing his application, he reported worsening of his conditions, specifically noting increased back pain and the onset of panic attacks (Exhibit 8E, p. 2). He reported that his conditions affected his ability to care for his personal needs, noting that he had difficulty showering due to difficulty standing (Exhibit 8E, p. 6). The claimant alleged that his conditions affected his ability to lift, stand, walk, sit, squat, bend, kneel, climb stairs, reach, remember, complete tasks, concentrate and get along with others (Exhibits 3E, p. 9 and 4E, p. 6). Regarding his specific work-related physical limitations, he claimed that he could lift and carry only 15 pounds, sit for only one hour at a time, stand for only ten-to-15 minutes at a time and walk for only ten-to-15 minutes at time (Exhibits 3E, pp. 9 and 12 and 4E, pp. 6 and 9). Regarding his specific work-related mental limitations, he claimed that he could pay attention for only 20 minutes, that she did not finish what he started, that he had problems following written instructions and that he did not handle stress or changes in routine well (Exhibits 3E, pp. 9-10 and 4E, pp. 6-7).

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After careful consideration of the evidence, the undersigned finds that the claimant's medically determinable impairments could reasonably be expected to cause the alleged symptoms; however, the claimant's statements concerning the intensity, persistence and limiting effects of these symptoms are not entirely credible. The record does not support the claimant's allegations of disabling physical symptoms. At a June of 2012 consultative mental examination, the claimant walked with a normal gait and displayed no obvious physical impairments or pain behaviors (Exhibit 4F, p. 2). His ability to walk normally in June of 2012, two months after his amended alleged onset date, is not consistent with his allegations of disabling symptoms dating back to April of 2012. In July of 2012, the claimant presented to Mohammad Naziruddin, M.D., for a consultative physical examination (Exhibit 5F). He reported that he experienced low back pain radiating to his hips for about 18 or 20 years, noting that he suffered three gunshot wounds at that time (Exhibit 5F, p. 1). He stated that he never received epidural injections and never underwent back surgery (Exhibit 15F, p. 1). On examination, the claimant had no ankle edema (Exhibit 5F, p. 2). Examination of the spine revealed significant spasm with marked tenderness of the thoracolumbar spine (Exhibit 5F, p. 2). He demonstrated limited forward flexion to 40 degrees, extension to zero degrees, lateral flexion to zero degrees and rotation to ten degrees (Exhibit 5F, p. 2). On neurological examination, there was no evidence of any sensory, motor or neurological deficits (Exhibit 5F, p. 2). X-rays of the right hip performed at that time showed no evidence of fracture of significant degenerative disease (Exhibit 5F, p. 3). X-rays of the lumbosacral spine showed degenerative disc disease at L4-L5 (Exhibit 5F, pp. 3-4). Dr. Naziruddin did not offer opinions regarding the claimant's specific work-related functional abilities (Exhibit 5F). The claimant's thoracolumbar tenderness and reduced range of motion support the exertional and postural limitations in the above-referenced residual functional capacity finding. However, the objective imaging and the claimant's lack of motor or neurological deficits suggest that he can indeed perform the sedentary work contemplated by the above-referenced residual functional capacity finding.

In April of 2013, the claimant presented to the emergency room complaining primarily of gastrointestinal issues (Exhibit 14F, p. 12). On examination at that time, he had normal and symmetric muscle tone and strength (Exhibit 14F, p. 13). Moreover, he exhibited a normal gait (Exhibit 14F, p. 13). In October of 2013, the claimant presented to the emergency room with complaints of back pain (Exhibit 12F, p. 14). He stated that he had the pain after he jumped off a porch and then walked 30 blocks earlier that day (Exhibit 12F, p. 15). On examination, the claimant had no lower extremity weakness with normal muscle strength and tone (Exhibit 12F, p. 16). On musculoskeletal examination, he had no local bony tenderness but there were bilateral paravertebral spasms; trigger point areas elicited symptoms (Exhibit 12F, p. 16). The claimant had adequate range of motion and straight leg raises were negative (Exhibit 12F, p. 16). The claimant's normal gait and normal strength in April of 2013 are not consistent with the claimant's allegations that he cannot sustain even sedentary exertional work. Moreover, the claimant's adequate range of motion, the negative straight leg raises and the claimant's lack of lower extremity weakness even when he complaining of exacerbated symptoms in October of 2013, further suggests that his conditions are not as severe as alleged.

In February of 2014, the claimant presented to the emergency room with complaints of left leg pain (Exhibit 13F, p. 67). On musculoskeletal examination, the claimant had trace pitting lower extremity edema (Exhibit 13F, p. 68). A left lower extremity venous duplex scan performed at

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that time showed chronic echogenic debris throughout the femoral vein and popliteal vein with only partial compression felt to represent chronic deep vein thrombosis rather than acute deep vein thrombosis (Exhibit 13F, p. 77). These objective findings are consistent with the claimant's underlying medically determinable impairment of deep vein thrombosis. However, they are not consistent with the claimant's subjective complaints regarding the severity of that condition, particularly when considered in combination with the relatively mild clinical abnormalities noted by examiners. A March of 2014 left lower extremity venous duplex ultrasound showed finding suggestive for acute/sub-acute on chronic deep venous thrombosis within the femoral popliteal venous system of the left lower extremity (Exhibit 15F, p. 20). At that time, Michael Weinstein, M.D., prescribed the claimant Coumadin (Exhibit 15F, p. 21). Dr. Weinstein continued the claimant on Coumadin the following month (Exhibit 15F, p. 16). May of 2014 x-rays of the lumbar spine showed degenerative disc disease with probable small bullet fragments (Exhibits 11F, p. 7 and 16F, pp. 1-2). X-rays of the hips performed the same day were negative (Exhibit 11F, p. 2). In April of 2014, the claimant presented to the emergency room with complaints of back pain (Exhibit 13F, p. 61). On examination, he had tenderness to palpation over his lower back (Exhibit 13F, p. 62). He had increased pain with range of motion, but he nonetheless demonstrated normal range of motion (Exhibit 13F, p. 62). A neurological examination was normal (Exhibit 13F, p. 62). In May of 2014, Dr. Weinstein increased the claimant's dose of Coumadin (Exhibit 15F, p. 7). Once again, the claimant's back tenderness supports some limitations, but his retained range of motion and normal neurological functioning are consistent with the ability to perform the sedentary work contemplated by the above-referenced residual functional capacity finding. Moreover, while the objective imaging of the claimant's back and left lower extremity are consistent with his underlying medically determinable impairments, they are not consistent with the claimant's subjective allegations regarding the severity of his symptoms associated with those impairments.

In June of 2014, the claimant presented to the emergency room with complaints of left lower extremity pain and low back pain and a cough (Exhibit 13F, pp. 51-52). On examination, he exhibited no motor or sensory deficits (Exhibit 13F, p. 53). On musculoskeletal examination, the claimant had no tenderness in the extremities, he had full range of motion in the extremities and he had no edema in the extremities (Exhibit 13F, p. 53). A left lower extremity venous duplex Doppler ultrasound showed partial compressibility with intraluminal echogenic material throughout the femoral vein and popliteal that had a similar distribution and appearance when compared to the February of 2014 findings (Exhibit 13F, p. 58). There was note that the findings likely represented chronic deep vein thrombosis rather than acute deep vein thrombosis (Exhibit 13F, p. 58). The following month, the claimant returned to the emergency room with complaints of left leg pain (Exhibit 13F, pp. 42-43). On examination, the claimant was in no respiratory distress and his breath sounds were normal (Exhibit 13F, p. 44). On musculoskeletal examination, he had trace pitting edema in the lower extremity with calf tenderness (Exhibit 13F, p. 44). He exhibited no motor or sensory deficits (Exhibit 13F, p. 44). Another left lower extremity venous Doppler ultrasound showed diffuse wall thickening and incomplete compressibility of the left femoral-popliteal venous system that was stable compared to the prior study (Exhibit 13F, p. 49). The interpreting physician noted that the findings were consistent with previous chronic deep vein thrombosis and that there was no definitive superimposed acute thrombosis (Exhibit 13F, p. 49).

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Also in July of 2014, the claimant presented to Umar Shad, M.D., to establish care (Exhibit 15F, p. 1). The claimant reported that he had a history of deep vein thrombosis in the left lower extremity, for which he took Warfarin (Exhibit 15F, p. 1). Testing at that time revealed an INR level of 1.4 (Exhibit 15F, p. 1). On examination, the claimant had no edema in his extremities and his pulses and sensation were intact (Exhibit 15F, p. 2). The claimant had mild paraspinal lumbar muscle area tenderness (Exhibit 15F, p. 2). A neurological examination revealed no focal deficit (Exhibit 15F, p. 2). Dr. Shad increased the claimant's dose of Warfarin (Exhibit 15F, p. 2). The at most mild clinical abnormalities noted by Dr. Shad in July of 2014 are not consistent with the claimant's subjective allegations of extreme work-related functional limitations.

In August of 2014, the claimant presented to the emergency room with complaints of head injury following an altercation (Exhibit 13F, pp. 34 and 36). On examination, the claimant had symmetric reflexes with normal strength and tone (Exhibit 13F, p. 35). He had a steady gait (Exhibit 13F, p. 36). Later that month, he returned to the emergency room for removal of his sutures (Exhibit 13F, p. 29). On examination, he had no extremity tenderness and no extremity edema; he walked with a normal gait (Exhibit 13F, p. 29). In October of 2014, the claimant presented to the emergency room with complaints of upper respiratory symptoms (Exhibit 13F, p. 15). On examination, he had mildly painful range of motion in his back but he ambulated normally with a normal gait (Exhibit 13F, p. 17). These at most mild clinical abnormalities noted on physical examination, considered in combination with the claimant's demonstrated ability to ambulate normally, further suggest that he is capable of sustaining the range of sedentary exertional work in the residua functional capacity finding herein.

In November of 2014, the claimant presented to the emergency room with complaints of left leg and calf pain (Exhibit 13F, p. 3). A musculoskeletal examination revealed trace pitting lower extremity edema with calf tenderness (Exhibit 13F, p. 3). A left lower extremity venous duplex Doppler ultrasound showed diffuse wall thickening with partial compressibility of the left femoral popliteal venous system, similar to the prior study, most compatible with chronic deep vein thrombosis (Exhibit 13F, p. 12). It revealed no superimposed acute deep vein thrombosis (Exhibit 13F, p. 12). Once again, these objective findings are consistent with the claimant's medically determinable impairment of deep vein thrombosis but they are not consistent with the claimant's subjective complaints regarding the severity of that condition.

At the hearing, the claimant testified that he was not taking all of his pain medication for the previous month because he needed to start pain management in order to continue receiving the medication. Overall, the claimant's need for only conservative treatment for his physical impairments, the relatively mild abnormalities revealed by objective imaging and the lack of significant abnormalities noted during physical examinations suggest that the claimant retains the ability to perform the sedentary exertional work contemplated by the above-referenced residual functional capacity finding. The undersigned also notes that, at hearing, the claimant testified that he could lift eight pounds, sit for five-to-ten minutes at a time, stand for ten minutes at a time and walk three-to-four blocks. The above-referenced residual functional capacity accounts for these reported limitations by providing the claimant with the option to alternate between sitting and standing at will, at the sedentary exertional level. The undersigned notes, however, that these allegations are not fully consistent with the claimant's demonstrated ability to

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ambulate and his normal motor and neurological functioning; the above-referenced residual functional capacity takes into account those clinical findings.

The record does not support the claimant's allegations of disabling mental symptoms. There is evidence of the claimant's mental impairments dating back to before his amended alleged onset date (Exhibits 1F and 2F). In June of 2012, the claimant presented to Mark Pushkash, Ph.D., for a consultative examination (Exhibit 4F). He reported that he suffered from chronic depression and anxiety (Exhibit 4F, p. 2). The claimant reported that he was supposed to be on medication for his mental impairments but that he was not taking any medications because of his lack of health insurance (Exhibit 4F, pp. 1-2). He reported a considerable history of substance abuse, but he noted that he stopped that abuse about year before the examination (Exhibit 4F, p. 2). The claimant also stated that he had a history of numerous convictions for auto theft (Exhibit 4F, p. 2). On examination, the claimant sat with a relaxed posture and his overall level of motor activity was within normal limits (Exhibit 4F, p. 2). There was note that the claimant previously experienced some hallucinations, possibly associated with his substance abuse, but he denied hallucinations, delusions or paranoid thinking at the time of the examination (Exhibit 4F, p. 3). The claimant had a somewhat depressed mood with a subdued affect (Exhibit 4F, p. 3). He became tearful several times during the assessment (Exhibit 4F, p. 3). Regarding anxiety, he exhibited no behavioral signs of tension and he denied a pattern of excessive worry or panic (Exhibit 4F, p. 3). However, there was note that the claimant seemed to have to antisocial traits (Exhibit 4F, p. 3). Based on the examination, Dr. Pushkash offered a diagnosis of major depression, history of polysubstance dependence in remission and rule out antisocial personality traits (Exhibit 4F, p. 4).

In April of 2013, the claimant presented to the emergency room complaining primarily of gastrointestinal issues (Exhibit 14F, p. 12). On examination at that time, he had had intact recent memory and remote memory (Exhibit 14F, p. 13). In June of 2013, the claimant presented to the emergency room following a motor vehicle accident (Exhibit 14F, pp. 4-5). On examination at that time, he had a normal mood and affect (Exhibit 14F, p. 7). These normal findings are not consistent with the claimant's allegations of severe and disabling mental symptoms. In July of 2013, the claimant presented to Staci O'Dell N.P., for a mental health follow-up (Exhibit 15F, p. 25). There was note that he restarted his medication the previous month; he reported an overall improvement in his mood and anxiety level (Exhibit 15F, p. 25). On examination, the claimant was attentive to the conversation and his concentration and memory were intact (Exhibit 15F, p. 26). He had a pleasant mood with a brighter affect (Exhibit 15F, p. 26). Ms. O'Dell increased the claimant's dose of citalopram and continued the claimant with Seroquel (Exhibit 15F, p. 26). While the claimant exhibited somewhat increased symptoms at his June of 2012 consultative examination, Ms. O'Dell's July of 2013 observations, considered in combination with the observations noted by emergency room examiners in April of 2013 and in June of 2013, suggest that the claimant's symptoms subsequently improved considerably.

In October of 2013, the claimant presented to the emergency room with complaints of a cough and runny nose, among other things (Exhibit 14F, p. 2). On examination, he had a normal mood and affect with normal cognition (Exhibit 14F, p. 3). He had normal and logical associations with a normal reasoning pattern (Exhibit 14F, p. 3). There was no evidence of psychotic ideation (Exhibit 14F, p. 3). Later that month, the claimant presented to the emergency room with

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complaints of left leg pain (Exhibit 13F, p. 67). On examination at that time, he had a normal mood and affect (Exhibit 13F, p. 68). In April of 2014, the claimant presented to the emergency room with complaints of back pain (Exhibit 13F, p. 61). On examination, the claimant had a normal mood and affect (Exhibit 13F, p. 62). That month, the claimant followed-up with Ms. O'Dell (Exhibit 15F, p. 11). He walked with a limp at that time, noting that he had another blood clot and that it travelled to his lung (Exhibit 15F, p. 11). The undersigned notes that the claimant's statements at that time regarding a blood clot traveling to his lung are inconsistent with the objective imaging and testing discussed herein. On examination, the claimant was attentive to the conversation and his concentration and memory were intact (Exhibit 15F, p. 12). His mood was pleasant with a brighter affect (Exhibit 15F, p. 12). Ms. O'Dell continued the claimant with his medications (Exhibit 15F, p. 12). These consistently normal clinical observations noted on mental status examinations suggest that the claimant is able to perform the mental activities contemplated by the above-referenced residual functional capacity.

In June of 2014, the claimant presented to the emergency room with complaints of left lower extremity pain and low back pain, among other things (Exhibit 13F, pp. 51-52). On examination, the claimant had a normal mood and affect (Exhibit 13F, p. 53). In July of 2014, the claimant returned to the emergency room with complaints of left leg pain (Exhibit 13F, pp. 42-43). On examination, the claimant was anxious (Exhibit 13F, p. 44). Also in July of 2014, the claimant presented to Dr. Shad to establish care, as discussed above (Exhibit 15F, p. 1). On examination, the claimant was cooperative and he communicated well (Exhibit 15F, p. 2). He denied any suicidal ideation (Exhibit 15F, p. 2). In November of 2014, the claimant presented to the emergency room with complaints of left leg and calf pain (Exhibit 13F, p. 3). On examination, the claimant had a normal mood and affect (Exhibit 13F, p. 3). While the claimant exhibited symptoms of anxiety in July of 2014, the otherwise normal clinical findings noted by examiners suggest that the claimant's mental impairments are not as severe as alleged. Indeed, at hearing, the claimant suggested that his depression was not a significant problem when taking appropriate medication, consistent with Ms. O'Dell's observations regarding the claimant's improved presentation when compliant with his medication regimen.

The claimant has mild limitations in activities of daily living. In May of 2012, the claimant reported that he had some problems getting dressed, but he noted that those problems were physical in nature (Exhibit 3E, p. 5). He stated that he did not prepare his own meals, noting that he did not have the energy or ability to stand (Exhibit 3E, p. 6). The claimant stated that he helped with household chores, noting that he did laundry but that he needed help or encouragement (Exhibit 3E, p. 6). In June of 2012, the claimant reported that he had physical problems dressing, bathing and shaving, but he noted no mental limitations with such tasks (Exhibit 4E, p. 2). He stated that he was able to prepare himself basic meals such as sandwiches and noodles but that he was not able to do household chores (Exhibit 4E, p. 3). The claimant's reports in May and June of 2012 suggest that any limitations that he has in this domain primarily are physical in nature. At his June of 2012, consultative examination the claimant reported that he had no permanent residence, noting that he lived with various family members (Exhibit 4F, p. 2). He stated that he did not do much during the day, but he noted that he did look for part-time employment (Exhibit 4F, p. 2). Dr. Pushkash noted that the claimant had the skills to engage in all of his own cooking, cleaning, shopping and laundry (Exhibit 4F, p. 2). There was also note that, with regard to personal hygiene and self-care, the claimant was able to engage in basic

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activities of daily living in a self-initiated, self-directed and autonomous fashion (Exhibit 4F, p. 2). However, the claimant stated that he was not able to do much because of his chronic pain (Exhibit 4F, p. 2). Once again, these statements suggest that any limitations in this domain primarily are physical in nature. Moreover, as discussed above, the claimant's functioning improved since June of 2012. In addition, he reported no significant deterioration in his activities of daily living at hearing. Overall, this evidence supports no more than mild mental limitations in activities of daily living.

The claimant has mild limitations in social functioning. In May of 2012, the claimant reported that he went outside three times per week (Exhibit 3E, p. 7). He stated that he was able to go out alone, use public transportation, drive and shop in stores (Exhibit 3E, p. 7). The claimant reported that he talked with others on the telephone (Exhibit 3E, p. 8). He stated that he had problems getting along with family, friends or neighbors, noting that he was unable to afford his medication and that he was unable to handle stress (Exhibit 3E, p. 9). In June of 2012, the claimant reported that he rarely went outside but that he was still able to go out alone, drive and shop in stores (Exhibit 4E, p. 4). He reported that he still talked with others on the telephone but that he still had problems getting along with family, friends and neighbors (Exhibit 4E, p. 6). At his June of 2012, consultative examination the claimant reported that he did not have many friends; he stated that he disassociated himself from his friends because they were drug users (Exhibit 4F, p. 2). The claimant reported that he had problems getting along interpersonally and that he easily became irritated and frustrated (Exhibit 4F, p. 2). On examination, the claimant sat with a relaxed posture and his overall level of motor activity was within normal limits (Exhibit 4F, p. 2). As discussed above, examiners did not note significant social abnormalities on subsequent examinations. While the claimant presented as anxious on one occasion, he otherwise demonstrated a normal mood and affect. The undersigned also notes the claimant's testimony at hearing that, while he does not get along with his brother, he generally gets along with others. Overall, this evidence is consistent with only mild limitations in social functioning.

The claimant has moderate limitations in concentration, persistence or pace. In May of 2012, the claimant reported that he was able to pay bills, count change, handle a savings account and use a checkbook/money orders (Exhibit 3E, p. 7). He noted that he enjoyed watching sports on television (Exhibit 3E, p. 8). In June of 2012, the claimant reported that he still was able to manage money (Exhibit 4E, p. 4). He stated that he still enjoyed watching television (Exhibit 4E, p. 5). At his June of 2012 consultative examination, the claimant was able to recall six digits forward and three digits in reverse (Exhibit 4F, p. 3). He was able to recall two of three unrelated items after a ten-minute delay and he was able to do serial seven calculations to 50 without error (Exhibit 4F, p. 3). He stated that he was not able to multiply 17x3 without paper and pencil (Exhibit 4F, p. 3). The undersigned also notes that examiners noted normal observations with regard to the claimant's cognition and memory. Overall, this evidence supports no more than moderate limitations in concentration, persistence or pace.

The claimant has not experienced any episodes of decompensation of an extended duration. There is no evidence that the claimant required inpatient psychiatric hospitalization or that he experienced other symptoms consistent with an episode of decompensation. To the contrary, the claimant experienced relatively mild symptoms and required only conservative treatment.

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As for the opinion evidence, the undersigned gives little weight to the opinions regarding the claimant's physical limitations offered at the initial level by the State Agency medical consultant, Janis Byrd, M.D. (Exhibit 2A). She opined that the claimant could perform the full range of medium exertional work (Exhibit 2A). The undersigned finds that the claimant's has greater exertional and nonexertional limitations after considering the claimant's subjective complaints and his need for treatment in the emergency room on multiple occasions. The undersigned gives greater weight to the opinions regarding the claimant's physical limitations offered at the reconsideration level by the State Agency medical consultant, Mina Khorshidi, M.D. (Exhibit 4A). She opined that the claimant could perform the full range of sedentary exertional work (Exhibit 4A). While her opinion is consistent with the claimant's reported lower extremity symptoms and subjective complaints, the undersigned included somewhat greater nonexertional limitations as well as the change of position option after considering the claimant's testimony at hearing, his subjective complaints, his reported activities of daily living and his need for treatment in the emergency room on multiple occasions.

The undersigned gives little weight to the August of 2013 opinions offered by Christopher Weber, M.D. (Exhibit 10F). Dr. Weber opined that the claimant could stand and walk for only 45 minutes per day and that the claimant could sit for only 20 minutes at a time and stand and/or walk for only 45 minutes at a time (Exhibit 10F, p. 1). He noted that the claimant could sit, stand and walk for a total of zero hours per day (Exhibit 10F, p. 1). Dr. Weber opined that the claimant required unscheduled breaks during the day and that the claimant required the option to shift positions at will (Exhibit 10F, p. 1). Dr. Weber opined that the claimant could not lift any weight, could use his hands only 50 percent of the time, could use his fingers only 50 percent of the time and could never use his arms (Exhibit 10F, p. 2). Finally, Dr. Weber opined that the claimant would miss more work more than four times per month due to his impairments and need for treatment (Exhibit 10F, p. 2). Dr. Weber noted that he first saw the claimant on the day that he offered his opinions (Exhibit 10F, pp. 1-2). As such, he did not have the opportunity to consider the claimant's longitudinal functioning. Even considering the claimant's subjective complaints, the relatively mild abnormalities consistently revealed by objective imaging and the mild clinical abnormalities noted by examiners suggest that the claimant retains far greater functional abilities than those put forth by Dr. Weber. Finally, Dr. Weber's opinions are conclusory, encroach on areas of determination reserved for the Commissioner and are inconsistent with the claimant's own reports regarding his activities of daily living.

The undersigned gives some weight to the opinions regarding the claimant's mental limitations offered by the State Agency medical consultant at the initial level, Eric Edelman, Ph.D. (Exhibit 2A). He opined that the claimant had moderate restrictions of activities of daily living, had moderate difficulties maintaining social functioning, had moderate difficulties maintaining concentration, persistence or pace and had not experienced any episodes of decompensation of an extended duration (Exhibit 2A). Regarding the claimant's specific work-related functional limitations, Dr. Edelman opined that the claimant's history of depression would affect his ability to recall detailed instructions and that the claimant claimant's history of depression and personality features would affect his ability to sustain concentration, persistence or pace (Exhibit 2A). Dr. Edelman further opined that the claimant's conditions would affect his ability to interact with others (Exhibit 2A). The undersigned also gives some weight to the opinions regarding the claimant's mental limitations offered at the reconsideration level by the State

Agency medical consultant, Esther Lefevre, Ph.D. (Exhibit 4A). She offered similar opinions as those offered by Dr. Edelman with regard to the psychiatric review technique, with the exception that Dr. Lefevre opined that the claimant had only mild restrictions of activities of daily living (Exhibit 4A). Dr. Lefevre affirmed Dr. Edelman's opinions regarding the claimant's specific work-related mental abilities (Exhibit 4A). The claimant's own reports in May and June of 2012, considered in combination with his subsequent improved mental functioning, suggest that he retains greater abilities in activities of daily living than posited by Dr. Edelman and greater abilities in social functioning that posited by Drs. Edelman and Lefevre. Moreover, while the claimant exhibited symptoms of anxiety on one occasion, he otherwise exhibited a normal mood and affect and he appeared to interact appropriately with examiners, suggesting that the claimant does not have work-related social limitations, contrary to the opinions offered by Drs. Edelman and Lefevre.

The undersigned gives great weight to the June of 2012 opinions offered by the consultative examiner, Dr. Pushkash (Exhibit 4F, p. 4). He opined that the claimant was able to comprehend, recall and follow-through on instructions but that the claimant had a mildly-to-moderately compromised ability to concentrate and persist on tasks (Exhibit 4F, p. 4). Dr. Pushkash further opined that the claimant would have difficulty relating appropriately to supervisors and coworkers in a work environment; he also noted that the claimant did not cope very well with day-to-day stress (Exhibit 4F, p. 4). Finally, Dr. Pushkash recommended that the claimant have a representative payee in the event that he received funding (Exhibit 4F, p. 4). Dr. Pushkash's opinions generally are consistent with his own observations and findings during the consultative examination. However, the undersigned finds that the claimant retains slightly greater functional abilities after considering the claimant's subsequent improvement with medication and the subsequent clinical observations noted by examiners, which were at most mild.

The claimant's brother, Loren Chapman acted as a collateral source of information during the examination (Exhibit 4F). Mr. Chapman stated that the claimant was not helpful with household chores (Exhibit 4F, p. 2). To the extent that Mr. Chapman's statements constitute opinions, the undersigned gives them very little weight. He offered his statements for information purposes, not as an opinion regarding the claimant's work-related functional abilities. Moreover, he is not an acceptable medical source and his statements are vague and imprecise.

The undersigned acknowledges that Mary Chapman completed the June of 2012 Function Report (Exhibit 4E). However, it appears that she completed this report on the claimant's behalf and that the statements included therein represent the claimant's accounts, not the opinions of Ms. Chapman. Indeed, there are many references therein to "my" and "I," suggesting that she simply reduced the claimant's reports to writing (Exhibit 4E). To the extent that these statements do indeed constitute the opinion of Ms. Chapman, the undersigned gives them little weight, as it appears that she relied primarily on the claimant's reports. Moreover, she is not an acceptable medical source and the claimant demonstrated considerable improvement in his mental functioning since June of 2012.

In sum, the above residual functional capacity finding is supported by the objective medical evidence, the claimant's history of treatment, the observations of examiners and the claimant's performance during the consultative examinations.

5. The claimant is unable to perform any past relevant work (20 CFR 416.965).

The claimant worked as an Iron Metal Worker, described as semi-skilled work (SVP of 4) and described as heavy exertional work. The claimant also worked as a Foundry Pourer, described as unskilled work (SVP of 2) and performed at the heavy exertional level. Finally, the claimant worked as a Hand Molder, described as semi-skilled work (SVP of 3) and performed at the heavy exertional level. The claimant performed these jobs at the substantial gainful activity level within the previous 15 years (Exhibits 3D, p. 1; 2E, p. 3; 13E, p. 1 and 15E, p. 1). Moreover, he worked in these capacities long enough to learn how to perform the jobs. As such, the claimant's work as an Iron Metal Worker, a Foundry Pourer and a Hand Molder constitute past relevant work. As hearing, the vocational expert testified that an individual with the above-referenced residual functional capacity could not meet the functional demands of an Iron Metal Worker, a Foundry Pourer or a Hand Molder. The undersigned accepts the testimony of the vocational expert and thus finds that the claimant is unable to perform his past relevant work.

6. The claimant was born on December 24, 1969 and was 42 years old, which is defined as a younger individual age 18-44, on the date the application was filed. The claimant subsequently changed age category to a younger individual age 45-49 (20 CFR 416.963).

7. The claimant has a GED and is able to communicate in English (20 CFR 416.964).

8. 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).

9. Considering the claimant's age, education, work experience, and residual functional capacity, there are jobs that exist in significant numbers in the national economy that the claimant can perform (20 CFR 416.969 and 416.969(a)).

In determining whether a successful adjustment to other work can be made, the undersigned must consider the claimant's residual functional capacity, age, education, and work experience in conjunction with the Medical-Vocational Guidelines, 20 CFR Part 404, Subpart P, Appendix 2. If the claimant can perform all or substantially all of the exertional demands at a given level of exertion, the medical-vocational rules direct a conclusion of either "disabled" or "not disabled" depending upon the claimant's specific vocational profile (SSR 83-11). When the claimant cannot perform substantially all of the exertional demands of work at a given level of exertion and/or has nonexertional limitations, the medical-vocational rules are used as a framework for decisionmaking unless there is a rule that directs a conclusion of "disabled" without considering

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the additional exertional and/or nonexertional limitations (SSRs 83-12 and 83-14). If the claimant has solely nonexertional limitations, section 204.00 in the Medical-Vocational Guidelines provides a framework for decisionmaking (SSR 85-15).

If the claimant had the residual functional capacity to perform the full range of sedentary work, a finding of "not disabled" would be directed by a Medical-Vocational Rule. However, the claimant's ability to perform all or substantially all of the requirements of this level of work has been impeded by additional limitations. To determine the extent to which these limitations erode the unskilled sedentary occupational base, the Administrative Law Judge asked the vocational expert whether jobs exist in the national economy for an individual with the claimant's age, education, work experience, and residual functional capacity. The vocational expert testified that given all of these factors the individual would be able to perform the requirements of representative occupations such as the following:

Job Title	SVP/Skill-Level	Exertional Level	Number of Jobs in the National Economy
Food Preparer	Unskilled	Sedentary	26,000
Lobby Attendant	Unskilled	Sedentary	17,000
Assembler	Unskilled	Sedentary	50,000
Office Helper	Unskilled	Sedentary	99,000

The undersigned acknowledges that the Dictionary of Occupational Titles describes the job of a Lobby Attendant as light exertional work. However, the vocational expert testified at hearing that individuals can perform the job either sitting or standing and that the job does not require any lifting. The number of such jobs included in the above-referenced table contemplates only the number of such jobs at the sedentary exertional level in the national economy. The undersigned also notes that the vocational expert testified that an individual with the above-referenced residual functional capacity could still perform the work of a Lobby Attendant and an Office Helper even if such an individual needed to use a cane when standing and walking. As such, the undersigned finds in the alternative that the claimant still would not meet the criteria for disability even if he required a cane for such activities. Finally, the vocational expert acknowledged at hearing that the Dictionary of Occupational Titles does not address the sit-stand option contemplated by the above-referenced residual functional capacity. She testified that she relied on published research regarding the need for a sit-stand option and on her 30 years of experience when testifying about the matter.

Based on the testimony of the vocational expert, the undersigned concludes that, considering the claimant's age, education, work experience, and residual functional capacity, the claimant is capable of making a successful adjustment to other work that exists in significant numbers in the national economy. A finding of "not disabled" is therefore appropriate under the framework of Medical-Vocational Rules 201.28 and 201.21.

See Next Page

10. The claimant has not been under a disability, as defined in the Social Security Act, since April 27, 2012, the date the application was filed (20 CFR 416.920(g)).

DECISION

Based on the application for supplemental security income protectively filed on April 27, 2012, the claimant is not disabled under section 1614(a)(3)(A) of the Social Security Act.

/s/ Brent C Bedwell

Brent C Bedwell
Administrative Law Judge

March 4, 2015
Date

LIST OF EXHIBITS

Payment Documents/Decisions

Component No.	Description	Received	Dates	Pages
HO 1A	Disability Determination Transmittal		09/04/2012	1
HO 2A	Disability Determination Explanation		09/04/2012	11
HO 3A	Disability Determination Transmittal		03/15/2013	1
HO 4A	Disability Determination Explanation		03/15/2013	11

Jurisdictional Documents/Notices

Component No.	Description	Received	Dates	Pages
HO 1B	T16 Notice of Disapproved Claim		09/05/2012	4
HO 2B	Request for Reconsideration		10/11/2012	3
HO 3B	T16 Disability Reconsideration Notice		03/15/2013	4
HO 4B	Request for Hearing by ALJ		04/22/2013	3
HO 5B	Appointment of Representative		04/26/2013	1
HO 6B	Representative Fee Agreement		04/26/2013	1
HO 7B	Objection to Video Hearing		10/24/2014	1
HO 8B	Hearing Notice		12/08/2014	26
HO 9B	Resume of Vocational Expert		12/08/2014	1
HO 10B	Acknowledge Notice of Hearing		12/15/2014	1
HO 11B	Representative Fee Agreement		11/19/2014	1
HO 12B	Appointment of Representative		11/19/2014	1

HO 13B	Misc Jurisdictional Documents/Notices	During hearing	01/21/2015	1

Non-Disability Development

Component No.	Description	Received	Dates	Pages
HO 1D	Application for Disability Insurance Benefits		05/01/2012	2
HO 2D	Application for Supplemental Security Income Benefits		05/01/2012	6
HO 3D	Summary Earnings Query		09/12/2013	1
HO 4D	New Hire, Quarter Wage, Unemployment Query (NDNH)		09/12/2013	2
HO 5D	Detailed Earnings Query		09/12/2013	2
HO 6D	Certified Earnings Records		09/12/2013	2
HO 7D	New Hire, Quarter Wage, Unemployment Query (NDNH)		12/31/2014	1

Disability Related Development

Component No.	Description	Received	Source	Dates	Pages
HO 1E	Disability Report - Field Office			to 05/01/2012	3
HO 2E	Disability Report - Adult			to 05/01/2012	7
HO 3E	Function Report - Adult		COLLINS, BRYAN DERRELL	to 05/24/2012	12
HO 4E	Function Report - Adult		MARY CHAPMAN	to 06/04/2012	9
HO 5E	Disability Report - Field Office			to 10/11/2012	2
HO 6E	Disability Report - Appeals			to 10/11/2012	6

HO 7E	Disability Report - Field Office		to 04/22/2013	2
HO 8E	Disability Report - Appeals		to 04/22/2013	8
HO 9E	Report of Contact		to 06/12/2013	1
HO 10E	Representative Correspondence		to 09/13/2013	11
HO 11E	Medications		to 10/18/2013	1
HO 12E	Recent Medical Treatment		to 10/18/2013	1
HO 13E	Work Background		to 10/18/2013	1
HO 14E	Claimant's Change of Address Notification-clmts COA	rep: Brad Myler	to 07/17/2014	1
HO 15E	Work Background		11/19/2014 to	2
HO 16E	Recent Medical Treatment		11/19/2014 to	1
HO 17E	Medications		11/19/2014 to	1

Medical Records

Component No.	Description	Received	Source	Dates	Pages
HO 1F	Office Treatment Records		HEALTHCARE FOR THE HOMELESS	to 08/23/2010	5
HO 2F	Office Treatment Records		MILWAUKEE CNTY JAIL	02/23/2008 to 01/04/2011	32

HO 3F	Medical Evidence of Record	OUTREACH COMMUNITY HEALTH CTRS		2
HO 4F	Consultative Examination Report	MARK PUSHKASH PHD/W ALLIS	to 06/18/2012	5
HO 5F	Consultative Examination Report	MOHAMMAD N FAREED MD	to 07/23/2012	4
HO 6F	Case Development Worksheet	DDS WISCONSIN	05/01/2012 to 09/05/2012	4
HO 7F	Case Development Worksheet	DDS WISCONSIN	10/11/2012 to 03/15/2013	3
HO 8F	Medical Evidence of Record	OUTREACH COMMUNITY HEALTH CTRS		2
HO 9F	Claimant-supplied Evidence	Outreach Community Health Center	06/26/2013 to 06/26/2013	3
HO 10F	Misc Medical Records	Dr. Christopher Weber	to 08/21/2013	2
HO 11F	Office Treatment Records	Aurora Sinai Medical Center	to 05/07/2014	10
HO 12F	Office Treatment Records	Wheaton Franciscan Healthcare All Saints	10/22/2013 to 02/10/2014	19
HO 13F	Office Treatment Records	Wheaton Franciscan Healthcare All Saints	02/10/2014 to 11/01/2014	95
HO 14F	Emergency Department Records	WFH - St. Francis Hospital	06/08/2011 to 10/29/2013	20
HO 15F	Medical Evidence of Record	Outreach Community Health Center, Inc.	07/24/2013 to 07/21/2014	28

HO 16F	Radiology Report	During hearing	Outreach Community Health Center	05/23/2014 to 07/21/2014	4

SOCIAL SECURITY ADMINISTRATION

Refer to: TLC

Office of Disability Adjudication
and Review
5107 Leesburg Pike
Falls Church, VA 22041-3255
Telephone: (877) 670-2722
Date: June 4, 2016

NOTICE OF APPEALS COUNCIL ACTION

Mr. Bryan Derrell Collins
Apt 101
1230 E Singer Circle
Milwaukee, WI 53212

This is about your request for review of the Administrative Law Judge's decision dated March 4, 2015.

We Have Denied Your Request for Review

We found no reason under our rules to review the Administrative Law Judge's decision. Therefore, we have denied your request for review.

This means that the Administrative Law Judge's decision is the final decision of the Commissioner of Social Security in your case.

Rules We Applied

We applied the laws, regulations and rulings in effect as of the date we took this action.

Under our rules, we will review your case for any of the following reasons:

- The Administrative Law Judge appears to have abused his or her discretion.
- There is an error of law.
- The decision is not supported by substantial evidence.
- There is a broad policy or procedural issue that may affect the public interest.
- We receive new and material evidence and the decision is contrary to the weight of all the evidence now in the record.

Suspect Social Security Fraud?
Please visit http://oig.ssa.gov/r or call the Inspector General's Fraud Hotline at 1-800-269-0271 (TTY 1-866-501-2101).

See Next Page

What We Considered

In looking at your case, we considered the reasons you disagree with the decision in the material listed on the enclosed Order of Appeals Council.

We found that this information does not provide a basis for changing the Administrative Law Judge's decision.

If You Disagree With Our Action

If you disagree with our action, you may ask for court review of the Administrative Law Judge's decision by filing a civil action.

If you do not ask for court review, the Administrative Law Judge's decision will be a final decision that can be changed only under special rules.

How to File a Civil Action

You may file a civil action (ask for court review) by filing a complaint in the United States District Court for the judicial district in which you live. The complaint should name the Commissioner of Social Security as the defendant and should include the Social Security number(s) shown at the top of this letter.

You or your representative must deliver copies of your complaint and of the summons issued by the court to the U.S. Attorney for the judicial district where you file your complaint, as provided in rule 4(i) of the Federal Rules of Civil Procedure.

You or your representative must also send copies of the complaint and summons, by certified or registered mail, to the Social Security Administration's Office of the General Counsel that is responsible for the processing and handling of litigation in the particular judicial district in which the complaint is filed. The names, addresses, and jurisdictional responsibilities of these offices are published in the Federal Register (70 FR 73320, December 9, 2005), and are available on–line at the Social Security Administration's Internet site, http://policy.ssa.gov/poms.nsf/links/0203106020.

You or your representative must also send copies of the complaint and summons, by certified or registered mail, to the Attorney General of the United States, Washington, DC 20530.

Time To File a Civil Action

- You have 60 days to file a civil action (ask for court review).
- The 60 days start the day after you receive this letter. We assume you received this letter 5 days after the date on it unless you show us that you did not receive it within the 5-day period.

See Next Page

- If you cannot file for court review within 60 days, you may ask the Appeals Council to extend your time to file. You must have a good reason for waiting more than 60 days to ask for court review. You must make the request in writing and give your reason(s) in the request.

You must mail your request for more time to the Appeals Council at the address shown at the top of this notice. Please put the Social Security number(s) also shown at the top of this notice on your request. We will send you a letter telling you whether your request for more time has been granted.

About The Law

The right to court review for claims under Title II (Social Security) is provided for in Section 205(g) of the Social Security Act. This section is also Section 405(g) of Title 42 of the United States Code.

The right to court review for claims under Title XVI (Supplemental Security Income) is provided for in Section 1631(c)(3) of the Social Security Act. This section is also Section 1383(c) of Title 42 of the United States Code.

The rules on filing civil actions are Rules 4(c) and (i) in the Federal Rules of Civil Procedure.

If You Have Any Questions

If you have any questions, you may call, write, or visit any Social Security office. If you do call or visit an office, please have this notice with you. The telephone number of the local office that serves your area is (877)405-7842. Its address is:

Social Security
1710 S 7th St
Suite 200
Milwaukee, WI 53204-3538

/s/ *Ronald M. Rogers*
Ronald M. Rogers
Administrative Appeals Judge

Enclosure: Order of Appeals Council

Bryan Derrell Collins	[redacted]
Claimant	Social Security Number
Wage Earner	Social Security Number

AC EXHIBITS LIST

EXHIBIT NO.	DESCRIPTION	NO. OF PAGES	COURT TRANSCRIPT PAGE NO.
Exhibit 18E	Undated correspondence from claimant	2	

EXHIBIT NO. 10F
PAGE: 1 OF 2

Appendix G

RESIDUAL FUNCTIONAL CAPACITY QUESTIONNAIRE

Patient: BRYAN COLLINS	DOB: 12/[redacted]/1969	SSN:

Please answer the following questions concerning your patient's impairments. If available, attach all relevant treatment notes, laboratory and test results.

1. Nature, frequency & length of contact: First visit 8/21/13
2. Diagnosis: lumbago with Sciatica and AC joint separation
3. Prognosis: Fair
4. Identify all of your patient's symptoms (including pain, dizziness & fatigue):
   Depression, chronic pain, AC separation, Sciatica
5. How often are your patient's symptoms associated with their impairments severe enough to interfere with the attention & concentration required to perform simple work-related tasks?
   ☐ Never ☐ Seldom ☐ Often ☐ Frequently ☒ Constantly
6. Identify the side effects of any medications which may impact their capacity for work, i.e. dizziness, drowsiness, stomach upset, etc.:
   N/A
7. Would your patient need to recline or lie down during a hypothetical 8-hour workday in excess of the typical 15-minute break in the morning, the 30-60 minute lunch, and the typical 15-minute break in the afternoon? ☒ Yes ☐ No
8. As a result of your patient's impairments, please estimate your patient's functional limitations if your patient were placed in a competitive work situation on an ongoing basis:
   a. How many city blocks can your patient walk without rest or significant pain? < 1
   b. Please circle the number of minutes that your patient can sit and stand/walk at one time:
      SIT: 0 5 10 15 (20) 30 45 60 STAND/WALK: 0 5 10 15 20 30 (45) 60
   c. Please indicate the total number of hours your patient can sit and stand/walk in an 8-hour workday:
      SIT: (0) 1 2 3 4 5 6 7 8 STAND/WALK: (0) 1 2 3 4 5 6 7 8
   d. Does your patient need a job which permits shifting positions at will from sitting, standing or walking? ☒ Yes ☐ No
   e. Will your patient need to take unscheduled breaks during an 8-hour workday?
      ☒ Yes ☐ No
      If yes, 1) How often do you think this will happen? constant
      2) How long will each break last before returning to work? 10 minutes

EXH
PAG

RESIDUAL FUNCTIONAL CAPACITY QUESTIONNAIRE - Page 2

Patient: BRYAN COLLINS | DOB: 12/ 1969 | SSN: [redacted]

f. How many pounds can your patient lift and carry in a competitive work situation?
("Occasionally" means less than 1/3 of the 8-hour workday; "Frequently" means 1/3 – 2/3 of the 8-hour workday)

	Never	Occasionally	Frequently
Less than 10 lbs.	X		
10 lbs.	X		
20 lbs.	X		
50 lbs.	X		

g. Does your patient have limitations in doing repetitive reaching, handling or fingering?
☒ Yes ☐ No

If yes, please indicate the percentage of time during an 8-hour workday during which your patient can use hands/fingers/arms for the following activities:

	HANDS: Grasp, turn, twist objects	FINGERS: Fine manipulation	ARMS: Reaching
Right:	50 %	50 %	0 %
Left:	50 %	50 %	0 %

9. Please estimate, based upon your experience with the patient, and based upon objective medical, clinical, and laboratory findings, how often your patient is likely to be absent from work as a result of their impairments or treatments.

____ Never	____ Three or four times a month
____ Once or twice a month	X More than four times a month

10. Is your patient a malingerer? ☐ Yes ☒ No

11. Are your patient's impairments (physical impairments plus any emotional impairments) reasonably consistent with the symptoms and functional limitations described in this evaluation? ☒ Yes ☐ No

If no, please explain:

12. Is your patient physically capable of working an 8 hour day, 5 days a week employment on a sustained basis? ☐ Yes ☒ No

8/21/13
Date

[signature] MD
Doctor's Signature | Title

Printed Name: Christopher Weber
Address: 2406 S. 20th St.
Milwaukee, WI 53215
Phone Number: 414 [redacted] 672-1353

Myler Disability 1-800-652-9626 (4-2010)

stuff up off the floor and try and throw it in the washing machine because he say he don't do nothing.

Q Okay. Okay. Is he older or younger than you?

A Younger.

Q Okay. Are there things that you enjoy doing that you're still able to do, things that maybe make you happy or maybe take your mind off the pain for a little bit?

A No. I like working on cars, but I don't have the strength to do it no more.

Q Okay. Do you watch TV during the day? Do you read? Do you do anything else?

A Watch TV.

Q TV?

A Yes.

ALJ: All right. That's all the questions that I have for you for the moment. Mr. Ryan, additional followup questions you have?

ATTY: Yes, Judge.

BY THE ATTORNEY:

Q Bryan, who is your current primary care physician?

A Dr. Rodriguez and Nurse Sue.

Q Okay. Who is Dr. Weber?

A That's my -- one of my other doctors I had before on the south side.

Q Okay. Was she like a primary care doctor or family

doctor for you?

A Primary care doctor.

Q Okay.

A I came in every two weeks to see her.

Q Okay. Now, the 12 milligram dose, is that broken up in two different dosages for you? Is it metformin?

A I take them all at one time.

Q Okay. But it's 10 milligram and 2 milligram?

A Ten and two, yeah. Milligrams.

Q Do you take that with food, or what's the regiment with that?

A With food.

Q And how long have you been on the seroquel?

A 19 years or better.

Q Okay. Any medication changes at all in the last three months?

A Just my coumadin. They raised it up because I kept on having problems with my left leg. It kept freezing up on me, so they raised it up. I went from five to 10, and they pushed it up to 12 now.

Q Okay. Do you ever experience falls even with the cane?

A Yes.

Q About how often is that happening would you say?

A Since they got my blood control, it was first -- it wasn't that often.

Q Well, what would be your best guess?

A It wasn't regular, no.

Q Okay. Any problem with stairs?

A Yeah, a little bit.

Q Okay. Why is that?

A Well, with stairs, I kind of bend a little bit, so I hurt my back. Then, my legs start getting a little numb.

Q Okay. So you have difficulty with bending as well?

A Uh-huh.

ATTY: Okay. All right. Thank you. I don't have any further questions for the Claimant, Your Honor.

ALJ: All right.

BY THE ADMINISTRATIVE LAW JUDGE:

Q Any problems you have getting along with other folks?

A Yeah, my brother.

Q Okay. The young brother that's living with you guys?

A Yes.

Q What issues do you have with him?

A I really don't have no issue with him. He has the issue with me.

Q Okay.

A See, like I said when I came home, I was doing pretty good, and I took care of everything, and I told my brother when I get my health back together, I want to make sure I take care of everything like I did before, and he has the issue with that, and