

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TENNESSEE
WESTERN DIVISION

LAVITA C. HILL,)
)
 Plaintiff,)
)
 vs.) No. 02-2165-MaV
)
 JO ANNE B. BARNHART,)
 Commissioner of)
 Social Security,)
)
 Defendant.)

REPORT AND RECOMMENDATION

The plaintiff, Lavita Hill, appeals from a decision of the Commissioner of Social Security, denying Hill's application for disability benefits under Title II of the Social Security Act, 42 U.S.C. § 401 et seq. The appeal was referred to the United States Magistrate Judge for a report and recommendation pursuant to 28 U.S.C. § 636 (b) (1) (B) and (C). For the reasons given below, it is recommended that Commissioner's decision should be affirmed.

PROPOSED FINDINGS OF FACT

Hill first applied for Social Security disability benefits on January 19, 1999, due to pain and numbness in her arms and legs, dizziness, fainting, and shortness of breath allegedly related to emphysema, fibromyalgia, arthritis, and chronic sinusitis. (R. at

67-69, 80.)¹ Her alleged date of onset of disability was November 24, 1995. (R. at 67.) Her application was denied initially and on reconsideration. Hill then filed a request for a hearing which was duly held on December 8, 1999, before an Administrative Law Judge ("ALJ"). (R. at 24.) The ALJ denied Hill's application for benefits on February 23, 2000. (R. at 12-19.) Hill appealed this decision to the Appeals Council; on January 18, 2002, the Appeals Council denied the request for review, leaving the ALJ's decision as the final decision. (R. at 3-4.) Hill filed this lawsuit in federal district court on March 11, 2002, pursuant to 42 U.S.C. § 405(g), to review the final decision. Her complaint alleges that several of the ALJ's findings were not based on substantial evidence and that the ALJ applied improper or incorrect legal standards.

At the time of the hearing before the ALJ, the plaintiff was 56 years old. (R. at 25.) She had a GED and no additional education or vocational training. (R. at 26-27.) Her last job was at a construction company office where she was a clerical worker from January 1980 to November 1995, working on and off with varied hours. (R. at 73.) She testified that she stopped working there

¹ The paperwork describing Hill's condition is dated December 31, 1998, (R. at 80), and the claim was filed on January 19, 1999, (R. at 67).

on November 24, 1995 due to a project ending and also to chronic health problems. (R. at 27, 72.) At this job, which was part-time with varied hours, the plaintiff answered the phone, wrote checks, and filled out reports. (R. at 28.) Hill's longest continuous employment was from July 1985 through October 1994, when she was the owner-operator of a convenience store and deli. (R. at 73.) In this line of work Hill lifted up to fifty pounds, frequently lifted ten to twenty-five pounds, walked for 8 to 10 hours per day, and stood for 8 to 14 hours per day. (R. at 73.)

Hill's daily activities at the time of the hearing included cooking breakfast, performing minor household chores, taking outdoor walks of less than a half-mile, and napping, usually twice per day. (R. at 31-32, 42.) She did "very little" yard work, (R. at 41), and "hardly ever" drove, (R. at 45, 46), but "sometimes" did grocery shopping, (R. at 33). She was able to dress herself and take care of personal needs. (R. at 41.) She denied having any particular hobbies or recreations. (R. at 42.) She testified that she often woke during the night with back pain and stayed awake for thirty minutes to two hours. (R. at 39.)

At the hearing, Hill testified concerning her medical problems and symptoms. She first testified to problems with fatigue. She testified that she had a breathing problem and got very tired, (R. at 30), and also that she got short of breath when walking more

than one to two blocks, (R. at 32), but that she did not get short of breath just from standing, (R. at 33). She attributed her fatigue to a combination of fibromyalgia and emphysema, (R. at 32), and had stopped smoking a few weeks before the hearing, (R. at 30). She was using an inhaler for relief of symptoms. (R. at 32.)

Hill also testified to back, shoulder, and hip stiffness and pain that she attributed to arthritis. (R. at 29, 33-34.) She testified to weakness and fatigue in her knees when standing. (R. at 33.) At the time of the hearing she had been receiving cortisone shots for inflammation and back pain. (R. at 33-34.) She also testified that she was taking the painkiller Endocet, (R. at 38), along with other medications listed on hearing exhibit 12E (see R. at 36-37, 125).² She testified that her medications made her drowsy and sick to her stomach. (R. at 28, 39.)

In addition, Hill testified to occasional swelling in the hands, legs, or feet, (R. at 40), and daily dizzy spells that might

² Along with Endocet, on exhibit 12E Hill listed the following prescription medications: 1) the bronchial dilator Albuterol by aerosol inhaler (two doses every four hours); 2) the antihistamine Cyproheptadine (4mg, twice daily); the anti-inflammatory Arthrotec (50/200, twice daily); the painkiller Hydroco/APAP (hydrocodone/acetaminophen 500mg, every 4 hours or as needed); Cimetidine for acid stomach/ulcer (400mg twice daily); and the heart medication Metoprolol (50mg twice daily). She also listed the following non-prescription medications: Tylenol Extra Strength for Headaches (2 daily); Aspirin (1 daily); Vitamin E (1 daily); Vitamin C (1 daily).

be associated with low blood sugar, (R. at 45-46). She also testified to receiving treatment for sinusitis and heart problems, (R. at 30), but did not specifically associate particular symptoms with these disorders except to say that heart medication made her nauseous, (R. at 39). She testified to feeling depressed in the sense of being "tired of not feeling good" but denied symptoms such as "crying or feeling really so I'm going to hurt myself." (R. at 40.)

Finally, Hill testified to her physical capabilities. She testified that she could walk for one to two blocks, but less than a half-mile, before becoming short of breath, (R. at 31-32); stand in one place from thirty minutes to one hour, (R. at 32-33, 42); and comfortably sit in one place for approximately thirty minutes, (R. at 34, 43). She testified that she probably could lift ten pounds and maybe could lift twenty. (R. at 33.) She testified that she could bend to pick up items and could lift them to chest height, probably several times in an hour, but could not easily lift items above chest height. (R. at 41.)

The medical record exhibits indicate that Hill received treatment from 1995 to 1998 with William Stewart, M.D., of the Foundation Medical Group; from 1997 to 1999 with Dr. Seaton of the Methodist Ambulatory Care Center; and in 1998 with G.B. Colvin, M.D. She also consulted briefly in the fall of 1988 with Dr. Crews

of Family Medicine; in December 1997 with Richard W. Babin, M.D. of River Bend Head and Neck Associates; and in March 1999 with Douglas Karmel, M.D. on behalf of the State of Tennessee Department of Human Services. The record also contains a CT report by Robert Cockroft, M.D. dated May 19, 1998; an RFC by a non-treating, non-examining physician dated March 15, 1999; and a pulmonary function test conducted by Barry R. Siegel, M.D. dated April 8, 1999. (R. at 2.)

From late October to early November, 1988, Hill complained of a continuous sore neck, nausea, and sinus drainage. (R. at 139.) She also reported stomach problems; diagnostic impressions indicate a possible ovarian cyst. (R. at 139.)

The medical records then reveal a treatment gap of several years. Hill began to treat again in March and April of 1995, when she reported to doctors for shoulder pain; apparently a blood sugar tolerance test was also conducted at this visit. (R. at 152.) She also complained of weight loss, fatigue, and night sweats. (R. at 154.) She was placed on the anti-inflammatory drug Naprosyn. (R. at 152.) In May and June of 1995, Hill reported joint pain and swelling, fever, and shoulder stiffness; the diagnostic impression was "arthritic symptoms." (R. at 151.) From July through September of 1995, Hill reported joint pain and sweating, and received ibuprofen and the antibiotic ampicillin. (R. at 150.) In

October of 1995, Hill complained of joint pain and intermittent swelling in the hands, knees, feet, and hips, as well as fatigue and night sweats. The record notes that she still was smoking at that time. A possible rheumatoid factor was noted. (R. at 149.) In December of 1995, Hill complained of swelling to her face, hands, and feet, as well as stiffness and pain in her back, hips, and knees. (R. at 148.) She was scheduled for a follow-up in six weeks. (R. at 148.) Her complaints in this time period were symptomatically treated with medications including Naprosyn, ampicillin, ibuprofen, mucus thinning drugs, and histamine. (See, e.g., R. at 150-51.)

In January and February of 1996, Hill reported chills and sinus congestion and drainage, as well as nervousness, difficulty in concentration, interrupted sleep, and cold flashes. (R. at 147.) She received prescriptions for Xanax (an antidepressant), ibuprofen (a non-narcotic painkiller) and amoxicillin (an antibiotic). (R. at 147.) The Xanax prescription was renewed once. (R. at 147.)

There is then another gap in treatment until the fall of 1997, when Hill reported sinus congestion and drainage, coughing, headaches, and sore joints, all of which were symptomatically treated. (R. at 191, 196.) On December 20, 1997, Richard W. Babin, M.D., of River Bend Head and Neck Associates, recommended

further diagnosis to rule out "systemic illness such as polyarteritis or lupus." (R. at 140.) He reported that a CT scan revealed clean sinuses as a result of past surgery. (R. at 140.) A December, 1997 lab test reported probable fibromyalgia but no significant presence of rheumatoid factor. (R. at 223, 228.) A December 1997 X-ray also revealed clear but mildly hyperinflated lungs. (R. at 215.)

In March of 1998, Hill received Tagamet and was advised to make an appointment before receiving another refill. (R. at 144.) She reported with muscle aches and knee and hand pain in April, 1998; the diagnostic impressions included gastritis and menopausal syndrome. (R. at 194-95.) X-rays of her knees and hands revealed slight osteopenia (a decrease in bone density) in hand, finger, and knee joints. (R. at 214.) The hands showed some symptoms associated with degenerative disease. (R. at 214.) A CT scan conducted May 19, 1998 revealed "evidence of sinusitis . . . to a moderate degree" involving all the sinuses. (R. at 155.) On June 15, 1998, Louis R. Chanin, D.O. confirmed the CT scan results and referred the plaintiff to G.B. Kip Colvin, M.D. for her headaches and nasal drainage. (R. at 159.) On August 3, 1998, Hill reported to Dr. Colvin, presenting with chronic nasal drainage, facial pain and pressure, and headaches. (R. at 158). For symptoms of dizziness, itching, and a diffuse rash, she reported to acute care

treatment on August 6, 1998; a diagnosis of fibromyalgia, menopausal syndrome, and nasal polyps was entered. (R. at 193.) Sinus surgery was planned, and a post-surgical report from Dr. Colvin reported good healing on September 14, 1998. (R. at 157.) In early November, 1998, the medical reports noted multiple tick bites sustained over the summer and diagnostic impressions including post-menopausal syndrome and sinusitis. (R. at 192.) Tagamet and Tylenol were prescribed for Hill's symptoms. (R. at 192.)

On January 19, 1999, Hill reported to David Seaton, M.D. complaining of dizzy spells and fainting precluded by nausea, hot flashes, and sweating. (R. at 187.) An X-ray revealed a normal-sized heart and clear lung fields. (R. at 211.) Blood work was ordered January 26, 1999, with a suspicion of hypoglycemia and to rule out Rocky Mountain Spotted Fever.³ (R. at 186.) Around the same time, Hill again reported sinus and back problems, and reported that bending caused back pain. (R. at 184.) She received

³ There is some evidence throughout the medical records indicating a suspicion of Rocky Mountain Spotted Fever. This infectious disease is transmitted by tick bites and characterized by fever, chills, muscle aches and tenderness, headache, and rash. (See, e.g., R. at 140, 150, 193 (noting diffuse red rashes).) Apparently Hill received a 30-day course of antibiotic treatment for this disease (R. at 187) but had no further follow-up (R. at 186). Test results in February, 1999 were negative for recent or active infection. (R. at 221.)

refills of Tagamet and the hormone replacement drug Prempro. (R. at 184.)

In February of 1999, Hill reported nervousness, loss of appetite, difficulty sleeping, and chills. (R. at 146.) Diagnostic impressions again included post-menopausal syndrome and additionally an impression of depression. She was continued on Xanax, Tagamet, and hormone replacement drugs. (R. at 146.) The following month, Hill reported she was not sleeping well but was otherwise feeling better, "including nerves." Possible depression was noted and a follow-up scheduled in four weeks. (R. at 145.)

On March 10, 1999, Douglas Karmel, M.D. prepared a consultative report for the State of Tennessee, Department of Human Services, Disability Determination Section. Hill detailed symptoms of headache, visual disturbance, abdominal pain, and muscle and joint pain throughout the body. (R. at 161.) Dr. Karmel's report indicates a full range of motion in all joints and in the spine. (R. at 162.) Dr. Karmel opined that the plaintiff occasionally could lift and carry up to fifty pounds for one-third of a work day; could frequently lift and carry up to twenty-five pounds for one- to two-thirds of a work day; and stand, walk, or sit, with normal breaks, for about six hours of an eight-hour work day. (R. at 162.) Dr. Karmel confirmed the existing diagnostic impressions of chronic pulmonary disease and fibromyalgia, but noted that he

had not reviewed Hill's medical records. (R. at 162.) Pulmonary function tests administered that day were deemed unreliable due to poor patient effort, even after bronchial dilation. (R. at 162.)

A Tennessee Department of Human Services analysis, dated March 15, 1999, five days later than Dr. Karmel's report, indicates that the fibromyalgia was "not really limiting." (R. at 177.) The analysis confirmed sinusitis and potential hypoglycemia but requested a repeat of the pulmonary function test with emphasis on initial effort. (R. at 177.) A second pulmonary function test was conducted on April 8, 1999, reporting good patient cooperation, understanding, and effort. (R. at 178.) It revealed a forced vital capacity ranging from 85% to 95% of predictions and a forced expiratory volume after one second that ranged from 71% to 82% of predictions. (R. at 178-179.)

Finally, a non-treating, non-examining physician conducted a Residual Functional Capacity Assessment (RFC). Dated April 13, 1999, the RFC duplicates Dr. Karmel's findings. It notes fibromyalgia, sinusitis, and dizziness without definite cause, but reports very little measurable limitation in function. (R. at 170.) The physician completing the RFC found that Hill could occasionally lift and carry up to fifty pounds for one-third of a work day; could frequently lift and carry up to twenty-five pounds for one- to two-thirds of a work day; and could stand, walk, or

sit, with normal breaks, for about six hours of an eight-hour work day. The report also indicated Hill could push and pull; could frequently climb, balance, stoop, kneel, crouch, and crawl; and that she had no manipulative limitations, no visual limitations, no communicative limitations, and no environmental limitations. (R. at 171-174.) The RFC specifically notes that there is no reason to believe Hill's functional capabilities were any more limited in November 1995, the claimed onset date. (R. at 171.)

After the RFC was conducted, Hill's treatment is documented for only two additional months. On May 12, 1999, X-rays revealed a normal lumber spine (R. at 208.) On June 16, 1999, Hill reported dizzy spells and continuous back problems over last couple months. (R. at 183.) An X-ray revealed normal pelvic and left hip images. (R. at 207.)

Entitlement to Social Security benefits is determined by a five-step sequential analysis set forth in the Social Security Regulations. 20 C.F.R. §§ 404.1520, 416.920. First, the claimant must not be engaged in substantial gainful activity for a period of not less than twelve months. 20 C.F.R. § 404.1520(c). Second, a finding must be made that the claimant suffers from a severe impairment. *Id.* Third, the ALJ determines whether the impairment meets or equals the severity criteria set forth in the Listing of Impairments contained in the Social Security Regulations. 20

C.F.R. §§ 404.1520(d), 404.1525, 404.1526. If the impairment satisfies the criteria for a listed impairment, the claimant is considered to be disabled. If the claimant's impairment does not meet or equal a listed impairment, the ALJ must undertake the fourth step in the analysis and determine whether the claimant has the residual functional capacity to return to any past relevant work. 20 C.F.R. § 404.1520(e). If the ALJ finds the claimant unable to perform past relevant work, then, at the fifth step, the ALJ must discuss whether the claimant can perform other work which exists in significant numbers in the national economy. 20 C.F.R. § 404.1520(f).

Using the five-step disability analysis, the ALJ in this case found, as the first step in the evaluation, that Hill had not engaged in any substantial gainful activity since her claimed onset date of November 24, 1995. (R. at 16.) The ALJ also noted that Hill "last met the insured status requirements for a period of disability and disability insurance benefits on September 30, 1997." (R. at 16.) Accordingly, he observed that Hill must establish she was under a disability prior to September 30, 1997. (R. at 16.)

At the second step in the five-step analysis, the ALJ found that chronic obstructive pulmonary disorder (COPD), fibromyalgia, and chronic sinusitis all met the twelve-month duration

requirement. (R. at 16.) The ALJ also determined that fibromyalgia and sinusitis met the regulatory definition of "severe" conditions prior to September 30, 1997. (R. at 18.)

At the third step, the ALJ determined that the record did not establish that Hill had, prior to September 30, 1997, an impairment or combination of impairments that would meet or equal the level of severity described for any listed impairment as set out in 20 C.F.R. Part 404, Subpart P, Appendix 1. (R. at 18.) In reaching this conclusion, the ALJ relied upon the opinions of the Disability Determination Service medical consultants issued at the initial application and reconsideration stages of the proceeding. (R. at 18.)

At the fourth step in the analysis, the ALJ determined that Hill had the residual functional capacity to perform past relevant work and that, therefore, she was not disabled. (R. at 19.) The ALJ based his decision on the medical opinions in the record, upon the underlying medical records, and upon Hill's subjective testimony. (R. at 18.) Because no treating physician records addressed the Hill's specific functional capacity, the ALJ relied on the DDS medical consultants' findings to find that Hill was capable of lifting, carrying, pushing, and pulling 20 pounds occasionally and ten pounds frequently; capable of standing, walking, and sitting for six hours in an eight-hour workday with

normal breaks; and free of nonexertional limitations. (R. at 18.) The ALJ found Hill's subjective evaluations only partially credible because of inconsistencies among Hill's statements, inconsistencies between Hill's statements and the medical evidence, inconsistencies in the described level of severity, and the "low level and infrequent nature" of Hill's medical treatment. (R. at 18.) The ALJ also found Hill's credibility reduced because she offered no explanation for her failure to seek disability benefits until nearly four years after the claimed date of onset. (R. at 18.)

In this fourth step, the ALJ found that Hill remained capable of performing her past relevant work of payroll clerk. (R. at 19.) Accordingly, he did not reach the fifth step to inquire whether the plaintiff was able to perform other work existing in significant numbers in the national economy.

PROPOSED CONCLUSIONS OF LAW

Judicial review of the Commissioner's decision is limited to whether there is substantial evidence to support the decision, and whether the Commissioner used the proper legal criteria in making the decision. 42 U.S.C. § 405(g); *Barker v. Shalala*, 40 F.3d 789, 794 (6th Cir. 1994); *Abbott v. Sullivan*, 905 F.2d 918, 922 (6th Cir. 1990). Substantial evidence is more than a scintilla of evidence but less than a preponderance and is such relevant evidence as a reasonable mind might accept as adequate to support

a conclusion. *Kirk v. Sec'y of Health and Human Servs.*, 667 F.2d 524, 535 (6th Cir. 1981).

In determining whether substantial evidence exists, the reviewing court must examine the evidence in the record taken as a whole and must take into account whatever in the record fairly detracts from its weight. *Abbott*, 905 F.2d at 923. If substantial evidence is found to support the Commissioner's decision, however, the court must affirm that decision and "may not even inquire whether the record could support a decision the other way." *Barker*, 40 F.3d at 794 (citing *Smith v. Sec'y of Health and Human Servs.*, 893 F.2d 106, 108 (6th Cir. 1989)). If supported by substantial evidence, the Commissioner's decision must be affirmed even if the reviewing court would have decided the case differently and even if substantial evidence also supports the opposite conclusion. See *Kinsella v. Schweiker*, 708 F.2d 1058, 1059 (6th Cir. 1983). Similarly, the court may not try the case *de novo*, resolve conflicts in the evidence, or decide questions of credibility. *Cutlip v. Sec'y of Health and Human Servs.*, 25 F.3d 284, 286 (6th Cir. 1994).

The crucial issue in this case is whether there is substantial evidence in the record to support the ALJ's determination that Hill was not under a disability prior to September 30, 1997, the date Hill's insured status expired. The plaintiff's brief does not

specify the particular steps of the ALJ's decision-making process with which she takes issue. Step one of the ALJ's decision-making process, however, is uncontested. Hill does not challenge the ALJ's determination of the onset date, nor his determination of the date insured status expired on September 30, 1997.

At the second step of the analysis, Hill objects to the ALJ's determination that both COPD and fibromyalgia, but no other "severe" medical conditions, including the sinusitis, existed prior to the expiration of insured status on September 30, 1997. (R. at 18.) Hill points to a medical evaluation by Dr. Babin, dated December 20, 1997, stating that Hill had related to him a "progressive history of myalgias, joint pain, rash and malaise." (R. at 140.) Dr. Babin also stated, "[i]t is my worry that this patient has some systemic illness." (R. at 140.) The ALJ's opinion did take into account, however, all medical treatment on record prior to September 30, 1997. (R. at 16.) Indeed, the record shows that between November 24, 1995, her alleged onset date, and September 30, 1997, the date her insured status expired, Hill consulted a physician not more than nine times: three times for office visits and four or five times for prescription refills. (See R. at 147-151.) The ALJ specifically noted a treating physician's diagnosis of post-menopausal syndrome in February 1996, (R. at 16), and a lack of any other "significant clinical findings,

definitive diagnosis, or specialist referral" prior to the expiration of insured status, (R. at 16). Accordingly, it is submitted that the ALJ's decision that complaints other than COPD and fibromyalgia were not "severe" during her insured status is based on substantial evidence.

At the third step of the analysis, Hill objects to the ALJ's determination that her condition failed to meet or equal the severity criteria set forth in the Listing of Impairments contained in the Social Security Regulations. 20 C.F.R. §§ 404.1520(d), 404.1525, 404.1526. Hill's objections fall into three general categories: first, that the ALJ misquoted her testimony about the severity of her symptoms and misconstrued certain items on the record bearing on symptom severity; second, that the ALJ wrongly evaluated her credibility; and, third, that the ALJ failed to consider depressive symptoms in combination with the other impairments.

As to the first set of contentions, the plaintiff takes issue with the ALJ's determination that she "drives, does yard work and housework, walks, and grocery shops." (R. at 17.) Hill protests that she testified only to doing "minor chores," (Pl.'s Brief at 4, quoting R. at 31-32), and that a reasonable construction of her testimony about driving would be that "the claimant drives very little but should not be driving," (Pl.'s

Brief at 5). Hill also submits that the ALJ overlooked specific items in the record when he determined that Hill denied side effects from her medications and did not attempt to relieve symptoms without medication. The government stipulates that the ALJ's decision contains some misstatements. (Mem. in Supp. of the Comm'r Decision at 4.) The government argues, however, that an ALJ's misstatements constitute harmless error because appropriate facts were applied in reaching the ultimate legal conclusions, and such conclusions were supported by the record.

An ALJ's mistake as to a fact on the record, or the mention of a fact not on record, does not justify overturning a decision that is otherwise supported by substantial evidence. *Compare Hawkins v. Secretary of Health and Human Services*, Civil Case No. 89-1438, 1989 U.S. App. LEXIS 19091, *12 at n. 1 (6th Cir. 1989) (unpublished) (finding an ALJ's reference to a non-existent negative test result was harmless error when the reference was made in a list of missing medical evidence) and *Diorio v. Heckler*, 721 F.2d 726, 728-29 (11th Cir. 1983) (finding ALJ's incorrect statements about a claimant's age and work history harmless error when ALJ used correct age and history in Medical-Vocational analysis and when the Medical-Vocational guidelines were superfluous to the disability determination) with *Berryhill v. Shalala*, Civil Case No. 92-5876, 1993 U.S. App. LEXIS 23975, *20-22

(6th Cir. 1993) (finding that Appeals Council's decision that a claimant's \$50 per month rent offset was unearned income was not based on substantial evidence and was not harmless error when it affected the amount of the benefit the claimant was entitled to receive).

It is undisputed that erroneous facts were used in the ALJ's evaluation of Hill's subjective symptoms. The ALJ, however, is required to consider only "symptom-related functional limitations and restrictions . . . which can reasonably be accepted as consistent with the objective medical evidence and other evidence."

20 C.F.R. 404.1529(c)(3).

It is submitted that, despite the ALJ's misstatements, there is substantial evidence on record to support the ALJ's determination of only mild functional limitations and restrictions. Although the ALJ incorrectly stated that Hill denied side effects from medication, he also considered her low level and low frequency of medical care. (R. at 18.) Although the ALJ stated that Hill did not attempt to relieve symptoms, the RFCs established very few functional limitations or restrictions. (R. at 170.) It would be error to reject an ALJ's entire opinion based on inconsistencies as to specific facts, if the finding was otherwise supported by substantial evidence on the record. See *Walker v. Bowen*, 834 F.2d 635, 643-644 (7th Cir. 1987) (citing *Stephens v. Heckler*, 766 F.2d

284, 287 (7th Cir. 1985) for the proposition that a court reviews judgments, not opinions). Accordingly, it is submitted that there is no error in the ALJ's conclusion that Hill was not suffering a severe symptom-related functional limitation.

Second, Hill contends that the ALJ improperly discredited her testimony because there is, contrary to the ALJ's assessment, an explanation for Hill's failure to earlier apply for benefits. She also claims that she left work in 1995 because of illness and a lack of work, rather than just a lack of work as the ALJ noted. (Pl.'s Brief at 6-7.) Although the record indicates that the ALJ may have overlooked or misconstrued specific testimony, again the record shows substantial evidence supporting the ALJ's overall determination of credibility. The ALJ observed a discrepancy between Hill's subjective complaints and her level of medical care. (R. at 18.) He also observed inconsistencies between Hill's testimony and the medical evidence on the subject of functional capacity. (R. at 17.) Further, a court must give vast deference to the ALJ's determinations of credibility. See *Cutlip*, 25 F.3d at 286. For the foregoing reasons, it is submitted that substantial evidence exists to support the ALJ's determination of partial credibility and that this determination should not be disturbed.

In her challenge to the ALJ's findings regarding severity of symptoms, Hill argues that the ALJ failed to consider physician

notes that indicate depressive symptoms and prescribe Xanax in 1996. (Pl.'s Brief at 8; R. at 145-47.) The ALJ, however, is obligated only to consider those symptoms that in combination may constitute severe medical disability. 42 U.S.C. § 423(d)(2)(B). He is not required to examine every piece of evidence on the record; it is enough that his decision clearly sets forth a rationale that is clear enough to permit judicial review. *Walker*, 834 F.2d at 643; *Gray v. Comm'r of Soc. Sec.*, Civil Case No. 00-CV-10434-BC, 2001 U.S. Dist. LEXIS 24687, *6 (E.D. Mich. 2001) (unpublished opinion) (citing *Walker*).

In this case, the ALJ acknowledged his obligation to review symptoms both singly and in the aggregate. (R. at 18.) The ALJ was justified in not discussing the depression because the record indicates that Hill was complaining of nervousness, poor sleep, hot flashes, chills, and decreased concentration rather than depression, (see R. at 145-46, 187), and the record reveals that Hill's complaints during this time, as reported to doctors, were primarily physical rather than mental, (see R. at 145-46, 187), and she only received Xanax for a limited period of time prior to September 30, 1997. It is, accordingly, submitted that the ALJ's failure to consider the impact of any possible depression does not weigh against his finding that the majority of the medical records indicate no severe functional impairment.

Hill finally argues that the ALJ erred in determining that she could return to past relevant work. Specifically, she contends the ALJ failed to properly consider exertional and nonexertional impairments by giving too much weight to the report of Dr. Karmel, a "one-shot" consulting physician who apparently had not seen the plaintiff's medical records, (Pl.'s Brief at 4, 9; R. at 162), and too little weight to records generated by treating physicians, (Pl.'s Brief at 9).

The proper weight to give the opinion of a treating physician is stated in the regulations:

Generally, we give more weight to opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) . . . 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.

20 C.F.R. § 404.1527(d)(2) (emphasis added). "It is well-settled that opinions of treating physicians should be given greater weight than those held by physicians whom the Secretary hired and who only examined the claimant once," *Farris v. Sec'y of Health and Human Servs.*, 773 F.2d 85, 90 (6th Cir. 1985), but treating physician opinions receive controlling weight only when they are supported by sufficient clinical findings and are consistent with the evidence,

20 C.F.R. § 404.1527(d) (2); *Cutlip*, 25 F.3d at 287.

In this case, the ALJ did not disregard the opinions of the Hill's treating physicians or substitute his own medical opinions for those of the treating physicians. Rather, the ALJ duly noted in detail the treating physicians' course of treatment. (R. at 16-17.) However, the lack of "detailed, clinical, diagnostic evidence" can render a treating physician's opinion less creditworthy. *Walters v. Comm'r of Social Security*, 127 F.3d 525, 530 (6th Cir. 1997). As the ALJ specifically noted, "there are no treating medical source statements regarding the claimant's specific functional capacity," (R. at 18), particularly as it relates to her condition prior to September 30, 1997. Hill's subjective statements are the only significant evidence of limited functional capacity, and the uncontroverted medical documentary evidence on record contradicts her assessment. Accordingly, it is submitted that the ALJ utilized the correct legal standard in relying on the uncontroverted consulting doctors' reports.

Hill alleges the ALJ erred in failing to record his observation of her "exceptionally frail" condition at the hearing. (Pl.'s Brief at 9.) While the ALJ did not discuss his observations of the plaintiff, the law does not require him to do so. The determination is made on the totality of the evidence, and the ALJ's obligation is only to set forth a rationale for his decision

that is clear enough to permit judicial review. *Walker*, 834 F.2d at 643; *Gray*, 2001 U.S. Dist. LEXIS 24687 at *6 (citing *Walker*). It is submitted that the ALJ has met this standard and accordingly that there is no error.

CONCLUSION

The totality of record indicates that the ALJ's decision was supported by substantial evidence at each step of the decision-making process. Further, the ALJ's acknowledged errors or omissions were harmless because the ultimate conclusions were made according to correct legal standards and supported by other unrelated substantial evidence on the record. Accordingly, it is recommended that the Commissioner's decision to adopt the ALJ's analysis as the Agency's final decision, should be affirmed.

Respectfully submitted this 6th day of May, 2003,

DIANE K. VESCOVO
UNITED STATES MAGISTRATE JUDGE