In the Case of Bradley J. Loy

Social Security No. 310-92-9208

This brief is submitted in support of the Request for Review previously filed herein on behalf of the Claimant, Bradley J. Loy. The Claimant contends that the ALJ's decision in this case contains significant errors of law and fact, requiring the award of benefits, reversal or remand for further proceedings.

EVIDENTIARY SUMMARY

The evidence was submitted at a hearing on October 30th, 2007 before Administrative Law Judge Barbara J. Welch. In short, it showed that Claimant has been afflicted with severe mental disorders, causing erratic and dangerous behavior, for most of his life. From the age of 8, Claimant has been diagnosed with severe impairments attributed to Attention Deficit Disorder Hyperactivity Disorder (ADHD) and Intermittent Explosive Disorder. (Exhibit 1F). Specifically, Claimant assaulted several teachers (breaking one teacher's leg – Exhibit 7F), misbehaved on the school bus, stabbed another student with a pencil, grabbed several students, fought with students, verbally assaulted teachers, made verbal threats to others, destroyed school property, disrupted classes, and made inappropriate and profane comments. (Exhibit 3F).

Beginning in 2005, doctors identified Claimant's inability to keep any job for more than 6 months because of his anger, often as a result of his inability to understand instructions because of low intellectual functioning. (Exhibit 5F). As of April 2007, doctors diagnosed Claimant with Bipolar Disorder with Mania and Psychosis because Claimant had attempted suicide twice, thinks crowds are watching him, fears being jumped by unknown persons, hears his name being called or sees people when no one else is around, believes others are talking about him, has hit his wife and step dad, and has had repeated confrontations at work where he hit his bosses, causing him to lose every job he has ever had.

Claimant spends days at a time in bed, isolated, and alternating with periods of intense activity where he responds impulsively and becomes violent and aggressive with family, friends, and co workers. Doctors characterize him as easily frustrated and angered, going on spending binges, difficulty sleeping, trouble concentrating, forgetting easily, often sad or angry, and can't finish tasks. (Exhibits 7F & 8F).

ARGUMENTS

1. **While the ALJ found that Claimant's ADHD, Intermittent Explosive Disorder, and low average intelligence were impairments that more than minimally impacted Claimant's**

ability to perform work related activity and were severe impairments within the meaning of the regulations, she erred in failing to find that the weight of the evidence supported a conclusion that Claimant's Bipolar Disorder is an impairment which meets or medically equals the listed impairment of 20 CFR Part 404, Subpart P, Appendix 1 (20 CFR 416.920(d), 416.925 and 416.926). See Appendix, Listing 12.04 Affective Disorders.

The ALJ's decision claims to have evaluated Claimant's medical evidence of Bipolar Disorder under Listing 12.04 as an Affective Disorder in addition to her evaluations under Listings 12.02 and 12.08 (Decision, p. 3), Yet, her only reference to Claimant's diagnosis of Bipolar Disorder appears on page 6 of the Decision:

> A second biopyschosocial psychiatric summary undergone in April of 2007 shows that . . . he was also diagnosed with bipolar disorder, which is a diagnosis that was based solely on the Claimant's statements. . . (Decision, page 6).

The fact is that there is no lab test to determine Bipolar Disorder. Instead, as Dr. Albert's notes reflect:

> A bipolar disorder diagnosis is made only by taking careful note of symptoms, including their severity, length, and frequency. The most telling symptoms of bipolar disorder include severe mood swings (going from extreme highs to extreme lows) that don't follow a set pattern.
>
> The psychiatrist will ask questions about personal and family history of mental illness. The doctor will also ask detailed questions about symptoms, including how long they last and how frequently they occur. Other questions will focus on reasoning, memory, ability to express oneself, and ability to maintain relationships. www.webmd.com/bipolar-disorder/guide/bipolar-disorder-diagnosis.

Thus, using established medical protocol, the diagnosis, which the ALJ summarily rejected out if hand as superficial because it was based only on Claimant's statements, was properly based on behavioral history and Claimant's statement of his feelings. Thus, there was no legitimate basis for the ALJ's disbelief or disregard of the treating doctor's proper clinical diagnosis of Bipolar Disorder. Yet, since this is the ONLY reference to, or consideration of Bipolar Disorder in the Decision, the ALJ's ignorance of proper diagnostic protocol for Bipolar Disorder is evident, making it clear that as a result, she rendered an erroneous decision.

Even beyond the ALJ's error and disregard for the truth of the clinical diagnosis, there was another big red, evidentiary flag that should have alerted her to an oversight in this decision. With just a passing glance, she referred to Exhibit 11E (Decision, p. 4) to mention that Claimant is currently prescribed Geodone and Lamictal. This reference should have triggered a more careful consideration of Bipolar Disorder under Listing

12.04 because these medications are used almost exclusively to treat Bipolar Disorder. As it would be malpractice to prescribe Bipolar medications to a person who did not suffer from Bipolar Disorder, the ALJ should have taken this tip to thoroughly consider that the Bipolar Disorder diagnosis was legitimate.

Geodon is a treatment for acute mania and mixed episodes associated with Bipolar Disorder. www.geodon.com/baboutgeodone.asp. It is not indicated for any other condition. Likewise, Lamictal is a maintenance medication for adults with Bipolar Disorder who are being treated for acute mood episodes although it can also be used to control epilepsy. www.lamictal.com/bipolar.

Both medications were and are currently prescribed for Claimant by Dr. Albert, whom Claimant has seen monthly at Wabash Valley Hospital since April 2007. (Decision, p. 4) At stated above, Dr. Albert diagnosed Claimant with Bipolar I Disorder, Manic Episodes with Severe Psychosis and noted functional impairments in activities of daily living, concentration, persistence, and pace, interpersonal functioning, and psychological functioning as well as ADHD (Exhibit 8F).

Even with these helpful hints, the ALJ failed to consider or analyze Bipolar Disorder at all. Rather, she rejected it out of hand, based only on her belief that a diagnosis based on a patient's statements cannot be valid. Had she considered it, there is more than sufficient evidence to reasonably conclude under Listing 12.04 that Claimant is disabled because of Bipolar Disorder.

Hence, if the ALJ had done an objective analysis of the evidence, particularly the opinion of Dr. Albert, as the treating physician, the correct result would have found weighty evidence in support of the conclusion that Claimant's Bipolar Disorder is an impairment which meets or medically equals the listed impairment of 20 CFR Part 404, Subpart P, Appendix 1 (20 CFR 416.920(d), 416.925 and 416.926). Thus, this decision must be remanded for a thorough and proper determination.

2. The ALJ failed to comply with 20 CFR §§ 404.1567, 404.1527(d)(2), 416.927 (d)(2), 404.1502 and 916.902 in not according adequate weight to the opinion of Dr. Albert, the Claimant's treating physician.

Under 20 CFR §§ 404.1502 and 916.902, a treating physician or source is defined thusly:

> Generally, we will consider that you have an ongoing treatment relationship with an acceptable medical source when the medical evidence establishes that you see, or have seen, the source with a frequency consistent with accepted medical practice for the type of treatment and /or evaluation required for your medial conditions. We may consider an acceptable medical source who has treated or evaluated you only a few times or only after long intervals (e.g. twice a year) to be your treating

source if the nature and frequency of the treatment or evaluation is typical for your condition. 20 CFR §§ 404.1502, 916.902.

Here, the evidence established that Claimant was diagnosed by Dr. Albert in April 2007 and continues to see him monthly. (Exhibits 7F & 8F). The regulations provide that the findings of a treating physician as to the severity of an impairment be accorded controlling weight if they are well supported by medically accepted clinical and laboratory diagnostic techniques and are not inconsistent with the other substantial evidence in the record. See 20 CFR §§ 404.1527(d)(2), 416.927 (d)(2). As the treating physician, Dr. Albert's opinion and diagnosis should have been controlling.

Specifically, Dr. Albert found that:

> Given Bradley's symptoms of manic episodes, followed by days of isolation and depression, he meets the criteria for Bipolar I (Disorder), most recent episode manic, with psychosis. (Exhibits 7F & 8F).

Properly applied, Dr. Albert's diagnosis should have controlled in this case. Yet, the ALJ preferred and applied her own "diagnosis" instead of the treating physician's diagnosis. Because she failed to give controlling weight to the treating physician's diagnosis, this decision must be reversed or remanded.

3. The ALJ failed to comply with 20 CFR § 404.1527 because she did not provide adequate reasons for rejecting Dr. Albert's opinion and diagnosis, as Claimant's treating physician.

With reference to the option of a treating physician, the Social Security regulations provide that:

> . . . we will always give five good reasons in our notice of determination or decision for the weight we give to your treating source's opinion." 20 CFR §§ 4044.1527(d)(2), 416.927(d)(2).

Similarly, SSR 96-1p provides:

> The notice of the determination or decision must contain specific reasons for the weight given to the treating source's medical opinion, supported by the evidence in the case record, and must be sufficiently specific to make clear to any subsequent reviewers the weight the adjudicator gave to the treating source's medical opinion and the reasons for that weight. SSR 96-1p.

As discussed in the preceding arguments, the ALJ refused to consider Dr. Albert's diagnosis of Bipolar Disorder, stating that her only reason for this refusal was because:

> . . . he was (also) diagnosed with bipolar disorder, which is a diagnosis that was based solely on the Claimant's statements. . . (Decision, page 6).

Patently then, this decision must be reversed or remanded because the ALJ failed to give sufficient, specific reasons that make clear why she discounted the diagnosis of the treating physician as mandated under SSR 96-1p.

5. The ALJ erred by refusing to objectively evaluate the medical opinion of Dr. Albert, Claimant's treating physician.

The ALJ is required to evaluate every medical opinion received. See 20 CFR §§ 404.1527(b), 416.927(b). The regulations specifically provide that:

> . . . regardless of its source, we will evaluate <u>every medical opinion we receive</u>. . . using the following factors:
>
> a. the examining relationship, with more weight accorded to a physician who has examined the claimant than one who has not,
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> b. the treatment relationship, including the length of treatment of the claimant, the frequency of examination and the nature and extent of the treatment relationship,
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> c. the support of the physician's opinion afforded by the medical evidence of record,
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> d. the consistency of the opinion with the record as a whole,
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> e. the specialization of the physician, with more weight accorded to a specialist than to a non-specialist. and
>
> f. other factors, including the amount of understanding of the Commissioner's disability programs and their evidentiary requirements and the extent to which an acceptable medical source is familiar with the other information in the case record. 20 CFR §§ 404.1527(d), 416.927(d).

As discussed above, if the medical source is a treating medical provider, the regulations require that the ALJ provide "good reasons" in the "notice of determination or decision for the weight we give your treating source's opinion." 20 CFR§§ 404.1527(d)(2), 416.927(d)(2).

In this decision, the ALJ rejected the diagnosis of the treating physician, Dr. Albert, without stating "good reasons" in her decision at all. In fact, the diagnosis was a clinically sound one, but the ALJ rejected it because she believed that it was only based on Claimant's statement, rendering it invalid. Thus, under these regulations, the ALJ's failure to consider and document her evaluation of Dr. Albert's medical evidence necessitates that the decision be reversed or remanded.

SUMMARY

Therefore, Claimant Bradley Loy specifically requests that the Appeals Council consider his entire case to determine whether review should be granted pursuant to 20 CFR § 404.970(a). The foregoing list of errors is not exhaustive and only represents the more significant errors upon which the Appeals Council could readily determine that remand or reversal is required. The Appeals Council is required to evaluate the entire case to determine if any other basis for granting review exists as set forth by 20 CFR § 404.970(a). If the Appeals Council does intend to limit its review to only those issues specifically raised herein, Claimant Best requests specific notice of such intent as well as the opportunity to submit additional arguments within Thirty (30) days of receipt of such notice.

Respectfully submitted,

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APPENDIX

12.04 ***Affective disorders***: Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one of the following:

1. Depressive syndrome characterized by at least four of the following:

a. Anhedonia or pervasive loss of interest in almost all activities; or

b. Appetite disturbance with change in weight; or

c. Sleep disturbance; or

d. Psychomotor agitation or retardation; or

e. Decreased energy; or

f. Feelings of guilt or worthlessness; or

g. Difficulty concentrating or thinking; or

h. Thoughts of suicide; or

i. Hallucinations, delusions, or paranoid thinking; or

2. Manic syndrome characterized by at least three of the following:

a. Hyperactivity; or

b. Pressure of speech; or

c. Flight of ideas; or

d. Inflated self-esteem; or

e. Decreased need for sleep; or

f. Easy distractibility; or

g. Involvement in activities that have a high probability of painful consequences which are not recognized; or

h. Hallucinations, delusions or paranoid thinking; or

3. Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes);

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Marked difficulties in maintaining concentration, persistence, or pace; or

4. Repeated episodes of decompensation, each of extended duration;

OR

C. Medically documented history of a chronic affective disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of decompensation, each of extended duration; or

2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or

3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.