ARGUMENTS IN SUPPORT OF ERRORS AND LAW REQUIRING REMAND FOR FURTHER PROCEEDINGS AS TO CLAIMANT JAMES HALL

1. While the ALJ found that Claimant's inguinal hernia, bilateral hearing loss, back disorder with degenerative disc disease, major depression and varicose veins were severe impairments under Step 2 of the disability analysis, he erred in not finding that Claimant's carpal tunnel syndrome was also a severe impairment under 20 C.F.R. 404.1520(c).

The medical evidence submitted in this case indicates that in addition to the severe impairments recognized by the ALJ, the Claimant suffers from Carpal Tunnel Syndrome. Yet, the ALJ failed to conduct the proper analysis or provide sufficient justification for ignoring the evidence of carpal tunnel syndrome.

The ALJ never identified any listing for the syndrome under which he analyzed whether the Claimant's carpal tunnel syndrome constituted a severe impairment. In considering whether a claimant's condition meets a listed impairment, an ALJ must discuss the listing by name and offer "more than a perfunctory analysis" of the listing. *Barnett v. Barnhart*, 381 F. 3d 664 (7th Cir. 2004) as cited in *Taylor v. Barnhart*, 189 Fed. Appx. 557, 2006 U.S. App. LEXIS 18810 (7th Cir. 2006).

Specifically, Claimant's medical evidence of record shows that:

> . . . has carpal tunnel bilaterally. Exhibit B1F176,
>
> . . . diagnosed with carpal tunnel bilaterally in 1994. . . surgery (for) carpal tunnel bilaterally 1994. . . assessment: Carpal tunnel. Exhibit B1F19, and
>
> . . . had bilateral carpal tunnel syndrome – still has some pain at the site of the surgeries. Exhibit 10F.

Yet the ALJ did not articulate any reason as to why his Step Two analysis was silent as to Claimant's carpal tunnel syndrome. Thus, as in *Taylor,* Id., no articulate reason for rejecting the medical evidence as to Claimant's syndrome has been stated. Therefore, the ALJ failed to conduct the proper analysis. He never considered it nor identified any listing that was used to analyze carpal tunnel syndrome by number or by name. Therefore, this case must be remanded for consideration as to whether Claimant's carpal tunnel syndrome constitutes a severe impairment under the appropriate listings of 20 C.F.R. 404.1520(c).

2. The ALJ failed to present a thorough and reasoned analysis of the effect of the combination of all of Claimant's impairments under 20 C.F.R. Part 404, Subpart P, App. 1 (20 C.F.R. §404.1520(d), thereby committing reversible error.

At Step Two of the disability analysis, the Administrative Law Judge (ALJ) found that Claimant has the following severe of impairments:

> inguinal hernia, bilateral hearing loss, back disorder with degenerative disc disease, major depression and varicose veins. Decision, p. 4.

At Step Three, the ALJ found that:

> . . . the claimant does not have an impairment or combination of impairments that meets or medically equals one of the listed impairments in 20 C.F.R. Part 404, Subpart P, Appendix 1 (20 C.F.R. §§ 404.1520(d), 404.1525, 404.1526, 416.920(d), 416.925, and 416.926). Decision, p. 4.

As set forth in the argument supra, the ALJ did not analyze or include carpal tunnel syndrome in the Step Two analysis. Logically then, if on remand or reversal, it is held that Claimant's carpel tunnel syndrome is a severe impairment, then the ALJ must consider whether Claimant's carpal tunnel syndrome, in combination with his other severe impairments meets or medically equals one of the listed impairments.

Social Security regulations are clear that an ALJ is charged with the responsibility to determine whether a claimant's impairment or combination of impairments meets or medically equals the criteria of an impairment listed in 20 C.F.R. §404.1520(d). When a claimant has several medical problems, the ALJ must consider his condition as a whole. *Barrett v. Barnhart*, 355 F.3d 1065 (7th Cir. 2004) as cited in *Sienkiewicz v. Barnhart*, 409 F.3d 798 (7th Cir. 2005).

Here, the ALJ failed to discuss evidence of the combination of all of Claimant's impairments. Failure to consider all impairments, singly and in combination with other impairments, is reversible error under SSR 02-01p[1]. The ALJ must consider all of the available medical evidence and assess with a thorough and reasoned analysis the effect of all of claimant's impairments. *Fleetwood v. Barnhart, 211 Fed. Appx. 736, 2007 U.S. App. LEXIS 199 (10th Cir, 2007).* Thus, this claim must be reversed or remanded for a complete analysis, and the ALJ must consider whether or not Claimant's carpal tunnel syndrome, in combination with his other severe impairments, meets or equals the requirements of a listing. Because the ALJ did not assess this matter with a thorough and reasoned analysis in that he ignored Claimant's carpal tunnel syndrome, reversible error has been committed, and this decision must be reversed and/or remanded.

[1] See also *Salazar v. Barnhart*, 468 F3d 615, 621, 622 (10th Cir. 2006) as cited in *Fleetwood v. Barnhart*, 211 Fed. Appx. 736, 2007 U.S. App. LEXIS 199 (10th Cir. 2007).

3. **The ALJ failed to adhere to the treating physician rule when he ignored the evidence from Dr. R. Newton, Dr. James T. Croner, Dr. Mike Riderle, and Dr. Edward Lovelace that Claimant has significant limitations, necessitating remand or reversal.**

On Page 7 of the Decision, the ALJ wrote:

> The objective clinical findings consistent with pain that are noted in the medical reports of James T. Croner, M.D. and Roger Newton, M.D. are discounted by medical expert, Dr. Gardner. . . . The undersigned accepts Dr. Gardner's medical expert testimony regarding the claimant's physical residual functional capacity. Decision, p. 7.

Yet under 20 CFR §§ 404.1502 and 916.902, a treating physician or source is defined as:

> 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 shows that Dr. Newton conducted a SSA examination in September 2005. He found that Claimant was unable to walk very far, bend, ride a bike, do household chores, lift, walk on heels and toes, hear and understand normal conversational voices and squat. Exhibit B1F19. Likewise in May 2008, Dr. Croner found that Claimant has reduced lumbosascral range of motion. Exhibit B, p.3. Further, the ALJ ignored the findings of Dr. Edward Lovelace. His findings in 2002 established a basis from which Claimant's impairments can be measured. Specifically, Dr. Lovelace found:

> Chronic back pain, carpal tunnel, hearing loss, varicose veins that are painful, burning and swelling, limited ability to stand and sit very long, activities of daily living are limited by physical and emotional status, severely depressed, anxious, avoids people due to being irritable and feeling worthless, cannot attend to and/or concentrate on environment, impaired memory, unable to resume past work, recommended to be considered for disability due to severity of his long term emotional distress. He has a major depressive disorder that is severe and chronic. Exhibit 15F1.

Finally, Dr. Mike Riderle, Ph.D. evaluated Claimant in October 2002, and advised that Claimant should be a candidate for disability benefits based on findings that he has a limited ability to remember and maintain concentration upon complex job instructions. He further indicated that claimant's unstable emotional condition would make it difficult for the claimant to interact appropriately with coworkers and supervisors. He also cautioned that even minor stressors aggravate the claimant's emotional symptoms. Decision, p. 8.

Nevertheless, the ALJ discounted the opinions of these treating doctors in favor of Dr. Gardner, the medical expert, who merely "reviewed the medical evidentiary record and listen(ed) to the claimant's testimony." but never physically examined Claimant nor spoke with him. Decision, p. 6. Expectedly, Dr. Gardner found that none of the claimant's impairments met the criteria for disability under the listed impairments. Decision, p. 6. Thus, the opinion of a medical expert who never examined Claimant trumped the findings of Four (4) treating doctors.

The Treating Physician's Rule, 20 C.F.R. 404.1527(d)(2), directs the administrative law judge to:

> . . . give controlling weight to the medical opinion of a treating physician if it is "well supported by medically acceptable clinical and laboratory diagnostic techniques" and "not inconsistent with the other substantial evidence". We expressed some puzzlement about the rule: Obviously, if the treating physician's medical opinion is well supported and there is no contradictory evidence, there is no basis on which the administrative law judge, who is not a physician, could refuse to accept it. Equally obviously, once well supported contradicting evidence is introduced, the treating physician's evidence is no longer entitled to controlling weight. At that point, the treating physician's evidence is just one more piece of evidence for the administrative law judge to weigh. The treating physician rule goes on to list various factors that the administrative law judge should consider, such as how often the treating physician has examined the claimant, whether the physician is a specialist in the conditions claimed to be disabling, and so forth. The checklist is designed to help the administrative law judge decide how much weight to give the treating physician's evidence. When he has decided how much actual weight to give it, there seems no room for him to attach a presumptive weight to it. *Bauer*, Id. citing *Hofslien v. Barnhart*, 439 F.3d 375 (7th Cir. 2006).

Thus, the regulations provide that the findings of a treating physician as to the severity of an impairment must 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). Further, the 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.

Further, caselaw indicates that an examining physician's opinion can be rejected only for reasons supported by substantial evidence in the record; a contradictory opinion of a non-examining expert does not, by itself, suffice. *Gudgel v. Barnhart*, 345 F.3d 467 (7th Cir. 2003) as cited in *Taylor*, Ibid.

Without any conflict in the medical evidence, the opinions of Claimant's Four (4) treating doctors should have controlling over the opinion of a medical expert who never examined the Claimant. Because the ALJ did not defer to the treating physician rule or the opinions of the treating doctors, this decision must be reversed and remanded for proper analysis and consideration.

4. **In analyzing Claimant's Residual Functional Capacity under 20 C.F.R. § 404.1520 (g), the ALJ found that a consulting psychologist's observation that Claimant "was malingering" was "most persuasive", thereby discounting Claimant's credibility, yet the ALJ failed to articulate his reasoning with required specificity as to the underlying factual findings which must "closely and affirmatively link" to substantial evidence of record that negates Claimant's credibility.**

As to the Residual Functional Capacity analysis, the ALJ concluded that:

Dr. Gatschenberger's diagnosis of malingering undermines the overall credibility of the claimant's testimony regarding the extent of his limitations of both a physical and psychological nature. Decision, p. 8.

Therefore, the ALJ found Dr. Gatschenberger's observation of malingering most persuasive, causing him to discount Claimant's testimony as not credible. Decision, p. 8.

An ALJ's credibility determination shall stand so long as the ALJ gives specific reasons for the finding that are supported by the record. *Taylor*, Ibid. citing *Brindisi ex rel Brindisi v. Barnhart,* 315 F.3d 783 (7th Cir. 2003). Thus, an ALJ's credibility determination will be overturned only if it is patently wrong. *Schmidt v. Barnhart*, 395 F. 3d 737 (7th Cir.

> 2005). Yet the Seventh Circuit Court of Appeals has repeatedly warned ALJs that they must be careful not to succumb to the temptation to "play doctor" and to avoid making their own independent medical assessments. *Schmidt v. Sullivan*, 914 F.2d 117, 118 (7th Cir. 1990).

Thus, where an ALJ's RFC determination is based in large part on his personal conclusion that the claimant exaggerated his subjective complaints and did not present a picture of a person suffering from chronic, severe, unrelenting pain, the ALJ's decision is flawed. Such a decision must be based on underlying factual findings that are "closely and affirmatively linked to substantial evidence and not just a conclusion in the guise of findings" even though a claimant's credibility is generally an issue reserved to the ALJ. *Hamby v. Astrue*, 260 Fed. Appx. 108, 2008 U.S. App. LEXIS 504 (10th Cir. 2008) citing *Hackett v. Barnhart*, 395 F. 3d 1168, 1173 (10th Cir. 2005).

As part of the RFC evaluation process, the ALJ must take into account any subjective allegations "which can reasonably be accepted as consistent with the objective medical evidence and other evidence." 20 C.F.R. § 404.1529(c)(3). He should give careful consideration to "the location, duration, frequency, intensity of . . . pain and other symptoms"; "precipitating and aggravating factors"; "type, dosage, effectiveness and side effects of any medication"; "treatment other than medications", for pain relief; and the claimant's "daily activities". *Id*.

Thus, the law is clear that the ALJ must analyze how the objective medical evidence relates to the claimant's subjective claims of pain and suffering. He must articulately discuss that interaction of evidence in the decision in order to conclude that a claimant's testimony is not credible. The ALJ must be sufficiently specific to make it clear to the individual and any subsequent reviewers the weight that the adjudicator gave to the individual's statements and the reasons for said weight. SSR 96-7p. Therefore, an ALJ cannot simply decide that he does not believe the testimony of a claimant or her family or her doctors as to the severity, duration, and frequency of symptoms and pain. Much more careful analysis is required.

Where, as here, medical evidence supports the claimant's testimony, and the ALJ nevertheless rejects a claimant's testimony as not credible, the ALJ cannot merely ignore the claimant's allegations and must articulate specific reasons for his finding as per SSR 96-7p. Those reasons must be supported by record evidence and must be sufficiently specific to make clear to the individual and to any subsequent reviewers the weight the adjudicator gave to the individual's statements and the reasons for that weight. *Lopez v. Barnhart*, 336 F. 3d 535, 2003 U.S. App. LEXIS 13806 (7th Cir. 2003) citing *Zurawdki v. Halter*, 245 F3d. 881 (7th Cir. 2001).

Yet in this case, the ALJ relied on the opinion of Dr. Gatschenberger, who saw Claimant once in 2002 as a consultant, that Claimant was malingering. Malingering in disability claimants is the act of conscious, gross exaggeration of symptoms or

impairment to obtain or maintain disability income.[2] With specific reference to the Diagnostic and Statistical Manual of Mental Disorders:

> Malingering is defined in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition-Text Revision (*DSM-IV-TR*) as the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding work or military duty; obtaining drugs or financial compensation; or evading criminal prosecution. The *DSM-IV-TR* further suggests that malingering should be strongly suspected with any combination of the following: Medicolegal context of presentation (as in disability evaluations), marked discrepancies between claims and objective findings, lack of cooperation with evaluations or treatment, or presence of antisocial personality disorder. Id.
>
> The article also shows that:
>
> • Malingering has been estimated to occur in 7.5% to 33% of disability claimants;
>
> • Because malingering is difficult to detect solely on the basis of unstructured interviews, clinicians should use as many sources of information as possible, including interviews with claimants, treatment providers, family members, and co-workers, clinical records psychological test reports, laboratory investigations, and work reports;
>
> • Factors that suggest the presence of malingering include motivation and circumstances of the claim that suggest determinants other than illness, atypical or exaggerated symptoms, inconsistencies in the presentation of claimants in interviews, and activity and behavior that is incongruent with the claims, and
>
> • Factors that argue against malingering include aggressive treatment, objective collateral corroboration, obvious and significant losses, and self-defeating behavior. Ibid.
>
> The article advises that:
>
> Circumstances of the claim, claimants' symptoms, and behavior in and out of the interview situation, need to be investigated in detail to elucidate the presence or absence of malingering. Psychologic tests are useful adjunctive measures that can help determine malingering. Id.

Yet, Dr. Gatschenberger based his opinion of Claimant's malingering solely on his one time evaluation of Claimant. Yet, as this article explains, a one time personal interview is a most unreliable method of diagnosing malingering. Specifically:

---

[2] Determination of Malingering in Disability Evaluations, Roger Z. Samuel, MD, and Wiley Mittenberg, PhD, Primary Psychiatry. 2005;12(12):60-68, www.primarypsychiatry.com/aspx/articledetail.aspx?articleid=122.

> Studies have shown that clinicians lack efficacy in detecting malingering or simulation solely on the basis of unstructured interviews. Psychiatrists detect approximately 50% of lies in interviews, which is no better than that which would be discovered by chance. While lying or simulation are not to be directly equated with malingering, these studies do inform that clinicians cannot distinguish between genuine, fake, or exaggerated complaints on the basis of demeanor. . . The demeanor, affect, facial expressions, and behavior in the interview should not be used as the sole criteria for determining the presence or absence of malingering, because psychiatrists and other clinicians are inaccurate in their detection of lying or simulations in interviews. The demeanor of the claimant is usually not a helpful clue in determining the presence of malingering. . . Techniques utilized to increase the accuracy of detection of malingering include using multiple sources of data, prolonged interviews, and psychologic tests that assess effort or "faking" during test taking. Forensic evaluations necessitate an examination of the nexus between compensable damage and symptoms that are corroborated by multiple data sources and not just by subjective complaints by the claimant. Clinical approaches may therefore not be adequate for differentiating exaggerated or malingered presentation from atypical cases. Ibid.

Hence, as established by the scientific studies cited in this article, Dr. Gatschenberger's opinion that Claimant was malingering is no more valid that if he had merely flipped a coin. Both methods render a 50/50 chance of validity.[3] The more responsible and statistically supportable method to determine whether a patient is malingering is a clinical test:

> Consider (this) point when facing the issue of malingering:
>
> 1. Review the medical records to see if a neuropsychologist or psychologist has evaluated the patient. Testing may include the Minnesota Multiphasic Personality Inventory (MMPI). The MMPI-2 has an F scale that is called the malingering index. It addresses symptoms that are stereotypically associated with serious psychopathology, but are rarely found in patients with serious disorders. Look at the conclusions of the report to determine if any comments were made about the F scale. The F-K score is another potentially useful indicator touted as having the ability to distinguish malingerers from non-malingering subjects.[4]

Although Dr. Gatschenberger did not administer an MMPI to Claimant in 2002, preferring to "flip a coin", fortunately Dr. Lovelace did administer an MMPI to Claimant

---

[3] Flip a coin for 50:50 randomization. Assignment of Subjects to Clinical Studies, Norman M. Goldfarb, Journal of Clinical Research Best Practices, Vol. 2, No. 4, April 2006. http://firstclinical.com/journal/2006/0604_Study_Assignment.pdf.

[4] Medical Topics: Malingering: Can it be Detected? www.medleague.com/Articles/medical_topics/detecting_malingering.htm

in 2002. Thus, while the ALJ ignored Dr. Lovelace's records in reaching his decision, Dr. Lovelace's MMPI of Claimant shows:

> . . . gave him the Minnesota Multiphasic Personality Test which reveals that he is experiencing a significant degree of psychological distress, intense depression, irritability and anxiety. Exhibit 15F1.

Noticeably absent from Dr. Lovelace's findings is the F scale or F-K score which determines malingering in the results of an MMPI. Thus, a clinical test administered by a psychologist during the same time period found no evidence that Claimant was malingering.

As it is well established that clinical evidence which contradicts the subjective "flip a coin" opinion expressed by Dr. Gatschenberger is definitively controlling, the clinical MMPI results should have been accorded controlling weight over the subjective 'flip a coin' opinion which the ALJ adopted in this matter. Since the clinical evidence supports Claimant's testimony (and conclusions from the treating doctor's evidence, which the ALJ also excluded in favor of a consultant's one time opinion) in that he was not malingering, the ALJ's decision that the claimant was not credible is wrong, and the ALJ fell short of the requisite standard in that he did not give specific and valid reasons for discrediting Claimant's testimony. While the ALJ need not discuss every piece of evidence, he must articulate some legitimate reason for his decision. He must build an accurate and logical bridge from the evidence to his conclusion. *Clifford v. Apfel*, 227 F.3d 863, 872 (7th Cir. 2000). An ALJ's determination that the Claimant is not credible is entitled to "great weight" only if it is supported by "explicit," "specific," and "cogent" reasons for the ALJ's disbelief. *Bucholz v. Barnhart*, 566 Fed. Appx. 776 , 779 (9th Cir. 2003).

Here, the decision does not meet the required standard. Claimant's subjective statements must be credibly acknowledged where objective clinical evidence supports them. Apart from this, the ALJ is still required to "build an accurate and logical bridge" to support his decision. In this case, he did not do so, necessitating reversal or remand.

This point is particularly important because the credibility of Claimant's statements has significant ramifications. If his testimony had been appropriately credited, and "flip a coin" opinions discarded, the ALJ could have reasonably found that Claimant could not work at any occupation, entitling him to disability payments. Thus, this case must be reversed or remanded for a complete discussion as to the proper credibility to assign to Claimant's testimony and an explicit, specific, and cogent discussion of any disbelief that the ALJ may still have as to her credibility. Without further specificity as to why Claimant's testimony is not credible, the requirements of 20 C.F.R. § 404.1529(c)(3) have not been met, and this decision must be reversed or remanded to satisfy those requirements.

SUMMARY

Therefore, Claimant James Hall 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 requests specific notice of such intent as well as the opportunity to submit additional arguments within Thirty (30) days of receipt of such notice.

Based on the foregoing, Claimant respectfully requests that the Appeals Council reverse the ALJ's determination and award benefits. Alternatively, the Appeals Council should remand this matter for further proceedings as set forth herein.

Respectfully submitted,

POWER, LITTLE & LITTLE

Attorneys for Claimant James Hall

____

By C. David Little