

**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF INDIANA
FORT WAYNE DIVISION**

KAREN EICHER,)	
)	
Plaintiff,)	
v.)	CAUSE NO.: 1:04-CV-5
)	
JO ANNE B. BARNHART,)	
Commissioner of Social Security,)	
)	
Defendant.)	

MEMORANDUM OF DECISION AND ORDER

I. INTRODUCTION

Plaintiff Karen Eicher (“Eicher”) seeks judicial review¹ of the final decision of the Defendant Commissioner of Social Security, Jo Anne Barnhart (“Commissioner”), who found that Eicher was not entitled to Social Security Disability Insurance Benefits (“DIB”) because her impairments did not prevent her from performing her past relevant work. *See* 42 U.S.C. §§ 416(i) and 423(d).

For the following reasons, the Commissioner’s final decision will be REVERSED and REMANDED for rehearing.

II. FACTUAL AND PROCEDURAL BACKGROUND

During her application process² for DIB, Eicher has been evaluated by over thirteen

¹All parties have consented to the Magistrate Judge. *See* 28 U.S.C. § 636(c).

²Eicher filed her initial application for DIB on February 17, 1999 and alleged July 15, 1996 as her disability onset date. (Tr. 87.) On July 17, 2001, the ALJ issued an unfavorable decision denying her benefits. (Tr. 59-66.) On August 16, 2001, Eicher filed a subsequent claim for DIB and Social Security Income (“SSI”). (Tr. 74.) On March 22, 2002, the Appeals Council issued an order remanding her initial case to the ALJ and consolidating her subsequent claim for DIB and SSI. (*Id.*) On July 9, 2003, the ALJ issued a decision denying both claims for DIB, (Tr. 18-27), and the Appeals Council affirmed this decision of the ALJ on November 6, 2003. (Tr. 9-12.) It is from this decision that Eicher appeals. (Compl.)

different physicians. Seven evaluations were performed by Social Security (“SS”) physicians, with the remaining evaluations completed by her treating physicians.³ In determining that Eicher was not entitled to DIB, the Administrative Law Judge (“ALJ”) gave greater weight to the opinions of one SS consultative examiner, one State Agency examiner, and one consulting physician than to the opinions of her treating neurologists, Drs. Romain and Chang. (Tr. 25.) He also disbelieved Eicher’s testimony concerning her allegations of inability to work and her symptoms of pain. (*Id.*) For the sake of brevity, this opinion focuses on the opinions of these physicians and discusses others only as necessary.

A. Eicher’s Medical History

In November 1999, Eicher’s general practitioner, Dr. Miller, suspecting peripheral neuropathy⁴, referred her to neurologist Dr. Romain. (Tr. 333-34.) When she saw Dr. Romain on December 9, 1999, Eicher complained of problems in her legs, left arm, and numbness in her fingers. (Tr. 263-271.) Dr. Romain performed a physical, took a medical history and ordered

³Per the request of SS, Dr. Ungemach examined Eicher on April 13, 1999 (Tr. 248-49); Dr. Holton examined her on August 25, 1999 (Tr. 249-51); Dr. Shah examined her on November 13, 2000 and again on September 23, 2002 (Tr. 350-45; 509-14); Dr. Schubert examined her on November 16, 2000 (Tr. 355-62); Dr. Kancherla examined her on October 23, 2001; and Dr. Dodson performed a Residual Functional Capacity (“RFC”) assessment on November 28, 2001.

Eicher’s treating physicians include Dr. Miller, a general practitioner, whom she saw from May 1974 through February 1999 (Tr. 220-45); Dr. Bond, a general practitioner, whom she saw from June 1999 through June 2000 (Tr. 331-40); Dr. Romain, a neurologist, whom she saw from December 1999 through August 2001 (Tr. 258-97, 344-49, 366-419, 433-38); Dr. Chang, a neurologist, whom she saw from November 2001 through April 2002 (Tr. 455-70, 476-77, 493-98); and Dr. Hatch, a pain management specialist, whom she saw from February 2002 through June 2002 (Tr. 500-08).

On January 16, 2002, Dr. Young, a neurosurgeon, examined Eicher at the request of Dr. Chang (Tr. 455-56), and on May 28, 2002, Dr. Shugart, an orthopedic surgeon, examined her at the request of Dr. Hatch. (Tr. 478-80).

⁴A disease, or disorder, affecting the nerves of the central nervous system. The American Medical Association Encyclopedia of Medicine (Charles Clayman, ed., Random House 1989).

extensive testing.⁵ (Tr. 267.) Dr. Romain initiated treatment that involved medication, mechanical traction, electrical stimulation, and ultrasound as well as the use of epidural blocks. (Tr. 321-28; 367; 373-407.)

On July 10, 2000, Dr. Romain completed a residual functional capacity questionnaire in which he diagnosed Eicher with cervical spondylosis⁶ with spasticity⁷ and osteophytic⁸ disease, C-6 radiculopathy⁹ secondary to intra-foraminal stenosis¹⁰, and L3-S1 disc bulge. (Tr. 344.) Her symptoms included numbness, pain and burning in the legs and forearms, and right arm pain. (*Id.*)

At the request of SS, Dr. Shah, a neurologist, performed a consultative exam on November 13, 2000. (Tr. 350.) Eicher told Dr. Shah her legs had been going numb for years and she had chronic phlebitis,¹¹ for which she had been taking Coumadin. (*Id.*) In addition, she reported burning pain in her legs, feet, and left arm but did not mention she was having back

⁵From December 1999 through January 2001, Dr. Romain ordered the following tests: cervical spine MRI, CT scan of the lumbar spine, electromyography, somatosensory evoked response testing (twice), venous doppler ultrasound, Galop antibody, motor and sensory neuropathy evaluator, cerebral spinal fluid, cervical spine post myelogram CT, lumbar spine post myelogram CT, total myelogram, multiple sclerosis evaluation, and a MRI lumbar spine. (Tr. 260, 262, 274-76, 284, 287, 289-91, 293-95, 297, 329-330, 409, 411, 413.)

⁶Cervical spondylosis is a degenerative condition of the spine and neck. Stedman's Medical Dictionary (William Dornette, ed., Anderson Publishing Company 5th Unabridged Lawyers ed. 1982).

⁷Spasticity is a state of increased muscle tone with exaggeration of the tendon reflexes. Stedman's Medical Dictionary, *supra* note 6.

⁸Osteophyte is a localized outgrowth of bone that forms at the boundary of a joint. Osteophytes are characteristic of osteoarthritis and are partly responsible for the deformity and restricted movement of affected joints. American Medical Association Encyclopedia of Medicine, *supra* note 4.

⁹Radiculopathy is any disease of the roots of spinal nerves. Stedman's Medical Dictionary, *supra* note 6.

¹⁰Stenosis is a narrowing of any canal. Stedman's Medical Dictionary, *supra* note 6.

¹¹Phlebitis is the inflammation of a vein, often accompanied by clot formation. The American Medical Association Encyclopedia of Medicine, *supra* note 4.

pain. (*Id.*) Dr. Shah conducted a neurological exam, which he found unremarkable, and noted that Eicher had “some tenderness as to percussion over the thoracic region.” (*Id.*) He concluded that Eicher had musculoskeletal pain involving her back. (Tr. 351.)

Apparently, Dr. Shah was not sent, and accordingly could not have reviewed, any of Eicher’s neurological testing completed prior to the November 13, 2000, exam. (Tr. 363-64.) Eicher’s attorney brought this oversight to the attention of the ALJ in December 2000 (*id.*), but nothing appears to have been done to correct it.

In early 2001, at the request of Eicher’s attorney, Dr. Romain completed an additional questionnaire in which he reviewed and commented upon the opinions of three SS consultative examiners (Drs. Ungemach, Holton, and Shah) plus some clinical notes from Dr. Bond. (Tr. 416-19.) In addition, Dr. Romain explained why he performed each of the medical tests he ordered for Eicher, how the tests were performed, what the tests demonstrated, and how these tests indicated Eicher’s symptoms and functional limitations. (*Id.*)

In November 2001, Eicher began treatment with another neurologist, Dr. Chang. (Tr. 469.) At her initial visit on November 1, 2001, Dr. Chang conducted a neurological exam and concluded her cranial nerves were essentially normal. (Tr. 470.) However, he cautioned her that given her treatment for the past nineteen years, he was not optimistic that he could sort out a specific diagnosis or provide definitive treatment. (*Id.*) In an effort to find the cause of Eicher’s symptoms, Dr. Chang conducted a number of tests¹² and consulted with several

¹²From November 2001 through December 2002, Dr. Chang ordered an electromyography, nerve conduction study, cerebral vascular exam, MRI of cervical spine, MRI of brain, and a lumbar puncture under fluoroscopic assistance. (Tr. 451-53, 464-66, 472, 520.)

physicians.¹³ Dr. Chang eventually diagnosed Eicher with cervical radiculitis,¹⁴ cervical spinal stenosis,¹⁵ neck and lower back pain, headaches, cerebral vascular disease, hypertension, and a peripheral blood clot. (Tr. 493.)

On November 28, 2001, Dr. Dobson, a State Agency physician, completed a Residual Functional Capacity (“RFC”) Assessment and concluded Eicher retained the capacity to stand and/or walk about six hours in an eight hour workday, lift twenty pounds occasionally, and lift ten pounds frequently. (Tr. 444.) Dr. Dobson indicated that “certain allegations appear to exceed medical findings.” (Tr. 448.) However, in the file he examined, there was no treating physician’s statement regarding Eicher’s physical capacities. (Tr. 449.)

At the suggestion of Dr. Chang, Eicher was examined by Dr. Young, a neurosurgeon on January 16, 2002. Dr. Young reviewed Eicher’s medical history, conducted a physical examination, and reviewed her 12/21/01 cervical MRI and 1/14/02 brain MRI to conclude that she was not a surgical candidate. (Tr. 455-56.) He opined that the cervical MRI demonstrated a C5-6 disc degeneration with a mild acquired central stenosis and moderate left-sided foraminal narrowing, and that the brain MRI demonstrated changes more consistent with a demyelinating process such as multiple sclerosis. (*Id.*)

In February 2002, Eicher began treatment with Dr. Hatch, a pain management specialist.

¹³Dr. Chang referred Eicher to Dr. Young, a neurosurgeon, in January 2001. (Tr. 462-63.) Dr. Chang also referred Eicher to Dr. Hatch, a pain management specialist, whom she saw on February 18, 2002. (Tr. 459.) Dr. Hatch referred Eicher to an orthopedic surgeon, Dr. Shugart, whom she saw on May 28, 2002. (Tr. 478-80.)

¹⁴Radiculitis is inflammation of the intradural portion of a spinal nerve root prior to its entrance into the intervertebral foramen or of the portion between that foramen and the nerve plexus. Stedman’s Medical Dictionary, *supra* note 6.

¹⁵*See* n.10, *supra*.

(Tr. 500-508.) Dr. Hatch referred Eicher to Dr. Shugart, an orthopaedic surgeon, whom she saw on May 28, 2002, for continued complaints of neck and back pain. (Tr. 478.) Even though Dr. Shugart diagnosed Eicher with chronic neck, thoracic and low back pain, he did not feel surgery was necessary because in his opinion, her pain was myofascial and would be better treated conservatively. (Tr. 479.)

Dr. Shah examined Eicher again on September 23, 2002. (Tr. 509-510.) In connection with this exam, Dr. Shah reviewed several of Eicher's medical records, including Dr. Shugart's May 28, 2002, exam notes, Dr. Chang's February 18, 2002 report and April 2002 report, and several test results, including her carotid ultrasound and December 2001 MRI scan of the cervical spine. (Tr. 510.) Dr. Shah concluded that Eicher described a variety of complaints but "her findings are few," and she had chronic back and neck pain, but it was non-surgical. (*Id.*)

Shortly after Dr. Shah submitted this report, Eicher's attorney wrote to the ALJ to note that some of the medical evidence Eicher had submitted contradicted some of Dr. Shah's findings. (Tr. 515.) In his report Dr. Shah indicated that Eicher's carotid ultrasound was negative, but this indication is inaccurate because only her left internal carotid artery was unremarkable; the right internal carotid artery showed forty to fifty-nine percent stenosis. (Tr. 515.)

The ALJ wrote to Dr. Shah to clarify the matter and enclosed copies of Dr. Shah's initial report, several MRIs, as well as comments from Dr. Romain concerning Dr. Shah's November 13, 2000, examination. (Tr. 431.) The ALJ asked Dr. Shah to review the MRIs and comment upon them prior to the March 7, 2001, hearing. (*Id.*) Dr. Shah responded by stating that he had read Dr. Romain's comments and "all [he] could say is that when [he sees] patients for Social Security evaluation very few records are available and [he has] to rely on the history given by the patient

and mainly the examination.” (Tr. 430.) He also added that he did not know what other tests had shown, but his neurological examination as indicated in his November 13, 2000, evaluation was not remarkable. (*Id.*)

B. The Administrative Hearing

On January 27, 2003, the ALJ conducted a hearing at which Eicher testified that she last worked in July 1996 as an office clerk, whose main duty was to enter data into the computer system. (Tr. 549-54.) She spent three quarters of her day keyboarding and even though she was able to work until the company went out of business, she experienced painful burning and numbness in her legs, arms and hands. (Tr. 555-57.) As a result, she had trouble grasping things and could not sit or stand for long periods of time because of painful burning and swelling in her legs. (Tr. 556.) She did not feel she could presently perform her job because her fingers and arms are numb all the time. (Tr. 557.) In addition, she felt she would have difficulty sitting for an extended period of time. (Tr. 558.) To deal with the pain she experiences, Eicher attends various forms of physical therapy, takes medication, props her legs up and sits in a hot tub several times a week. (Tr. 559-69.)

Eicher’s daughter, Tracey Gibson (“Gibson”), also testified that her mother’s numbness has worsened since 1996. (Tr. 571.) According to Gibson, Eicher is no longer able to cook, mow the lawn, or keep up with all her household chores. (Tr. 571-72.)

C. The Opinion of the ALJ

On July 9, 2003, the ALJ issued his written decision denying Eicher’s claim for DIB, finding that she retained the RFC for sedentary work activity and could perform her past relevant work as an office clerk. (Tr. 21-27.) In reaching this conclusion, the ALJ rejected the opinion of

Dr. Romain because (1) he did not provide any tests to support his opinion, and (2) his opinion was not supported by any other doctor. (Tr. 24.) Thus, he determined that the opinions of Drs. Shah and Shugart were entitled to greater weight. (Tr. 25.) In addition, the ALJ found that Eicher's allegations of total inability to work due to multiple symptoms were not fully credible because, despite her allegations of disabling back pain, the MRI and EMG did not show any need for surgical intervention, plus she had a normal EMG. (*Id.*)

III. STANDARD OF REVIEW

Section 405(g) of the Social Security Act ("Act") grants this Court "the power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the [Commissioner], with or without remanding the case for a rehearing." 42 U.S.C. § 405(g).

The Court's task is limited to determining whether the ALJ's factual findings are supported by substantial evidence, which means "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Young v. Barnhart*, 362 F.3d 995, 1001 (7th Cir. 2004). The decision will be reversed only if it is not supported by substantial evidence or if the ALJ applied an erroneous legal standard. *Clifford v. Apfel*, 227 F.3d 863, 869 (7th Cir. 2000).

To determine if substantial evidence exists, the Court reviews the entire administrative record, but does not reweigh the evidence, resolve conflicts, decide questions of credibility, or substitute its judgment for the Commissioner's. *Id.* Rather, if the findings of the Commissioner are supported by substantial evidence, they are conclusive. *Jens v. Barnhart*, 347 F.3d 209, 212 (7th Cir. 2003). Nonetheless, "substantial evidence" review should not be a simple rubber-stamp of the Commissioner's decision. *Clifford*, 227 F.3d at 869.

IV. DISCUSSION

Under the Act, a plaintiff is entitled to DIB if she establishes an “inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to . . . last for a continuous period of not less than 12 months . . .” 42 U.S.C. § 416(i)(1); 42 U.S.C. § 423(d)(1)(A). A physical or mental impairment is “an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.” 42 U.S.C. § 423(d)(3).

In determining whether Eicher is disabled as defined by the Act, the ALJ conducted the familiar five-step analytical process, which required him to consider the following issues in sequence: (1) whether the claimant is currently unemployed; (2) whether the claimant has a severe impairment; (3) whether the claimant’s impairment meets or equals one of the impairments listed by the Commissioner, *see* 20 C.F.R. § 404, Subpt. P, App. 1; (4) whether the claimant is unable to perform her past work; and (5) whether the claimant is incapable of performing work in the national economy. *See* 20 C.F.R. § 404.1520; *Dixon v. Massanari*, 270 F.3d 1171, 1176 (7th Cir. 2001). An affirmative answer leads either to the next step or, on steps three and five, to a finding that the claimant is disabled. *Zurawski v. Halter*, 245 F.3d 881, 886 (7th Cir. 2001). A negative answer at any point other than step three stops the inquiry and leads to a finding that the claimant is not disabled. *Id.* The burden of proof lies with the claimant at every step except the fifth, where it shifts to the Commissioner. *Clifford*, 227 F.3d at 868. Eicher contends the ALJ improperly evaluated the medical opinions of two of her treating neurologists as well as her testimony concerning pain symptoms, which in turn led to the flawed conclusion at step four that

she retained the RFC to perform her past relevant work as an office clerk. The RFC is an assessment of what work-related activities the claimant can perform despite her limitations. *See* 20 C.F.R. § 404.1545(a)(1) (stating that one’s residual functional capacity is the most one can still do despite any limitations). Each of Eicher’s arguments will be considered in turn.

A. The ALJ improperly evaluated the opinions of Eicher’s treating neurologists.

The opinion of a treating physician who is familiar with the claimant’s impairments, treatments, and responses should be given great weight in disability determinations because of his greater familiarity with the claimant’s conditions and circumstances. *Clifford v. Apfel*, 227 F.3d 863, 870 (7th Cir. 2000). If the ALJ finds that the treating physician’s opinion is “well-supported by medically acceptable [evidence] and is not inconsistent with the other substantial evidence in [the] record,” it will be given controlling weight. 20 C.F.R. § 404.1527(d)(2). If the doctor had a lengthy treatment relationship, had reasonable knowledge about the impairment, and presents relevant evidence to support his opinion which is consistent with the record as a whole, more weight should be given to his opinion. *Id.* More weight should also be given to the treating physician’s opinion if he is a specialist. *Id.*; *see also* Social Security Ruling 96-2p (“Treating source medical opinions are entitled to deference and must be weighed using all of the factors provided in 20 C.F.R. § 404.1527.”)

Pursuant to these regulations, the Social Security Administration is required to explain the weight it gives to the opinions of treating physicians. 20 C.F.R. § 404.1527(d)(2) (“We will always give good reasons in our notice of determination or decision for the weight we give your treating source’s opinion.”) Failure to provide good reason for discrediting a treating source’s opinion is grounds for remand. *Clifford*, 227 F.3d at 870. Nevertheless, a treating physician’s

opinion that a claimant is disabled cannot be conclusive because the ultimate determination of whether a claimant is disabled is reserved to the Commissioner. 20 C.F.R. § 404.1527(e)(1).

Here, the ALJ stated “Although Dr. Romain discussed several tests and findings, he did not supply evidence of these tests. Dr. Romain’s opinion is also inconsistent with the other medical evidence in the file.” (Tr. 25.) The ALJ failed to give controlling weight to Dr. Romain’s opinion and neglected to clarify what weight (if any) he gave to Eicher’s other treating neurologist, Dr. Chang. The opinions of these two neurologists are related, so for purposes of clarification, Dr. Romain’s opinion will be analyzed prior to Dr. Chang’s opinion.

First, the ALJ failed to give controlling weight to the opinion of Dr. Romain and failed to support his explanation for doing so with substantial evidence. To the contrary, Dr. Romain did support his opinions with clinical and laboratory techniques. From December 1999 through January 2001, Dr. Romain conducted over ten types of clinical and laboratory tests, including a cervical spine MRI, CT scan of the lumbar spine, electromyography, somatosensory evoked response testing (twice), venous doppler ultrasound, Galop antibody, neuropathy evaluator, cerebral spinal fluid, cervical spine post myelogram CT, lumbar spine post myelogram CT, total myelogram, multiple sclerosis evaluation, and a MRI lumbar spine. (Tr. 260, 262, 274-76, 284, 287, 289-91, 293-95, 297, 329-330, 409, 411, 413.) Moreover, some of these test results¹⁶ were sent to SS, who in turn failed to send them to the consultative examiners, a fact which claimant’s attorney twice brought to the attention of the ALJ. (Tr. 363-64; 432.) In any event, the ALJ’s

¹⁶The Court is unable to determine which tests were sent to the examiners and which were not. When evaluating the weight to give an opinion of medical evidence, 20 C.F.R. § 404.1527(d)(6) states in relevant part, “When we consider how much weight to give to a medical opinion, we will also consider any factors you or others bring to our attention . . . [f]or example . . . the extent to which an acceptable medical source is familiar with the other information in your case record . . .” Therefore, if the SS examiner (i.e. Dr. Shah) was not familiar with Eicher’s medical record, his opinion should be given less weight.

conclusion that Dr. Romain failed to support his findings with medically acceptable evidence is simply wrong.

Next, the ALJ's conclusion that Dr. Romain's opinion is inconsistent with the other medical evidence in the file is also unsupported by substantial evidence. Dr. Romain diagnosed Eicher with cervical spondylosis with spasticity and osteopytic disease, C6 radiculopathy secondary to intraforaminal stenosis, and L3-S1 disc bulge. (Tr. 344.) Even though four of the six SS consultative examiners concluded that Eicher's examinations were unremarkable¹⁷, two made a diagnosis that might be compatible with, or similar to, that of Dr. Romain's. Dr. Holton diagnosed Eicher with lower extremity claudication, which is defined as lameness or limping, usually caused by blockage or narrowing of the arteries in the legs. Notably, a rarer cause is spinal stenosis (narrowing of the canal carrying the spinal cord), causing pressure on nerve roots that pass into either leg. (American Medical Association Encyclopedia of Medicine, *supra* note 4.) Dr. Kancherla diagnosed Eicher with mild sensory impairment on left upper and lower extremities with impaired vibration in both legs suggestive of peripheral neuropathy with normal muscle strength and tone. (Tr. 441.) Thus, Dr. Romain's opinion is not inconsistent with the opinions of Drs. Holton or Kancherla, both SS examiners.

Perhaps more importantly, it is evident that Dr. Romain's diagnosis is not inconsistent with the opinions of Eicher's other treating physicians, one a general practitioner and the other a neurologist. Eicher's treating general practitioner, Dr. Bond, suspected peripheral neuropathy as early as September 1999 and sent her to Dr. Romain to be evaluated a couple months thereafter. (Tr. 333-35.) Almost a year later, Dr. Romain confirmed Dr. Bond's diagnosis of peripheral

¹⁷Dr. Ungemach (Tr. 248-49) , Dr. Shah (Tr. 350-54, 509-511), Dr. Schubert (Tr. 355-362) and Dr. Dobson (Tr. 443-450) .

neuropathy. (Tr. 369.)

The other medical opinion which must be addressed is that of Dr. Chang, Eicher's treating neurologist from November 2001 through at least June 2002. The substance of Dr. Chang's opinion may lend support to Dr. Romain's diagnosis, and it merits independent discussion because the ALJ failed to designate what weight he gave it, if any.

Eicher began treating with Dr. Chang in November 2001, but it was not until January 2002 that he diagnosed Eicher with multilevel degenerative disc disease, mild acquired central stenosis, and moderate left-sided foraminal narrowing; he also noted that her MRI scan of the brain revealed abnormal ischemia.¹⁸ (Tr. 460.) Given Eicher's treatment for the past nineteen years, Dr. Chang was not optimistic that he could give a specific diagnosis or provide a definitive treatment option. (Tr. 470.) However, Dr. Chang conducted a number of tests and consulted with several physicians in order to accurately diagnose Eicher. By June 2002, when he completed the RFC questionnaire, Dr. Chang diagnosed Eicher with cervical radiculitis, cervical spinal stenosis, neck and lower back pain, headaches, cerebral vascular disease, hypertension, and a peripheral blood clot. (Tr. 493.)

Nevertheless, the ALJ in his opinion, focused only on the normal results of two initial tests Dr. Chang conducted, a nerve conduction study and electromyography. (Tr. 25.) In addition, the ALJ also emphasized that tests ruled out a diagnosis of multiple sclerosis. (*Id.*) Based on these three test results, the ALJ concluded that there was no evidence to support radiculopathy, plexopathy, isolate neuropathy, peripheral neuropathy or myopathy. (*Id.*) This conclusion is not supported by substantial evidence and fails to account for any of the other test

¹⁸Ischemia is insufficient supply of blood to a specific organ or tissue. American Medical Association Encyclopedia of Medicine, *supra* note 4.

results Dr. Chang, Dr. Young and Dr. Hatch reviewed. *See, e.g., Zurawski*, 245 F.3d at 887 (noting that failure to consider a relevant line of evidence requires remand).

Notably, Dr. Young, a neurosurgeon, opined that Eicher's 12/21/01 cervical MRI demonstrated disc degeneration with mild acquired central stenosis and moderate left-sided foraminal narrowing. He stated that the brain MRI demonstrated changes consistent with a demyelinating process. In May 2002, Dr. Shugart, an orthopaedic surgeon, diagnosed Eicher with chronic neck, thoracic and lower back pain. He did not recommend surgery because he thought her pain was myofascial and would be better treated conservatively. Of all Eicher's treating physicians, which include two neurologists, Drs. Romain and Chang, one pain management specialist, Dr. Hatch, and one general practitioner, Dr. Bond, none reach the conclusion that Eicher's symptoms are normal and attributable to one single cause. Moreover, even though both of Eicher's consulting physicians, Dr. Young, a neurosurgeon, and Dr. Shugart, an orthopaedic surgeon, determined that surgical intervention would not be the best course of treatment for her, neither reached the conclusion that her symptoms were normal or unremarkable. In short, although the diagnoses of Drs. Chang and Romain are not entirely the same, the ALJ's conclusion that Dr. Romain's opinion is inconsistent with that of Dr. Chang's, or any of Eicher's other treating physicians, is not supported by substantial evidence.

Next, while the ALJ did not specifically discredit Dr. Chang's opinion, it is not clear what amount of weight he gave it. Based on the ALJ's ultimate determination that Eicher was not entitled to DIB, it is logical to infer that he rejected Dr. Chang's opinion. However, under the regulations, the ALJ must give good reasons in the notice of determination for the weight assigned to the treating physician's opinion. 20 C.F.R. § 404.1527(d)(2). Because the ALJ

offered no explanation for the weight he gave to the opinion of Dr. Chang, the Court cannot properly review the ALJ's decision and must remand. *See Watkins v. Barnhart*, 350 F.3d 1297, 1300 (10th Cir. 2003) (remanding case to ALJ for same reason).

It is also important to emphasize several other factors the ALJ must consider before determining that the opinions of Dr. Romain, and possibly Dr. Chang, are not entitled to controlling weight. Significantly, Dr. Romain treated Eicher from December 1999 through at least August 2001 and often saw her twice a month during his treatment. Dr. Romain stated that he had spent "perhaps a hundred hours with the patient" and has personally reviewed every aspect of her testing, in addition to taking her history and conducting multiple exams. (Tr. 419.) Dr. Chang treated Eicher for over seven months. Thus, both Drs. Romain and Chang treated Eicher much longer than any of the SS examiners and due weight should be given to this factor. 20 C.F.R. § 1527(d)(2)(i) and (ii). Furthermore, as neurologists, both doctors are specialists in their fields, and greater consideration should be given to their opinion than to sources who are not specialists. 20 C.F.R. § 1527 (d)(5).

These factors stand in stark contrast to the opinions of the SS doctors whom the ALJ decided should be given controlling weight. For instance, even though Dr. Shah (a neurologist) is also a specialist in his field, he examined Eicher only twice and may or may not have reviewed her extensive neurological testing to reach his conclusions. (*See* n. 16, *supra*.) When asked to clarify what records he reviewed to reach his opinion, Dr. Shah was vague and failed to provide the requested clarification. (Tr. 430.) However, when confronted with a potential inconsistency in his opinion, Dr. Romain responded with a detailed four-page analysis supporting his opinion with medical testing and findings specific to Eicher's case. (Tr. 416-19.) Dr. Dobson, a State

Agency physician, did not even personally examine Eicher nor review any treating source's statement regarding Eicher's physical capacities when he completed her RFC assessment.

Because the ALJ improperly evaluated Dr. Romain's opinion and failed to articulate the weight he gave to Dr. Chang's opinion, the Court must remand.

B. The ALJ improperly rejected Eicher's testimony regarding her subjective symptoms of pain.

An ALJ may discount a claimant's subjective complaints of pain that are inconsistent with the evidence as whole but may not disregard complaints merely because they are not fully supported by objective medical evidence. *Knight v. Chater*, 55 F.3d 309, 314 (7th Cir. 1995). The absence of objective medical evidence is one factor to be evaluated along with (1) the claimant's daily activities; (2) the location, duration, frequency and intensity of the pain; (3) precipitating and aggravating factors; (4) type, dosage, effectiveness, and side effects of medication; and (5) functional limitations and restrictions. 20 C.F.R. § 404.1529(c)(3); *Knight*, 55 F.3d at 314. Other factors include the claimant's relevant work history and observations by treating physicians, examining physicians, and third parties. *Clifford*, 227 F.3d at 872.

Even though review of an ALJ's credibility assessment is deferential, *Shramek v. Apfel*, 226 F.3d 809, 811 (7th Cir. 2000), the ALJ's determination in this case cannot be upheld. The ALJ did not believe Eicher's testimony concerning her multiple symptoms because the "MRI and EMG do not show any need for surgical intervention", the EMG was normal, and she had a full range of motion. (Tr. 25.) The ALJ overlooked significant pieces of evidence that related directly to the factors enumerated in the regulations. Most notably, the ALJ brushed aside the findings on Eicher's most recent MRI of the cervical spine (Tr. 494) and a CT scan that showed abnormalities in her lumbar spine. (Tr. 293-94.) It is illogical to conclude that simply because

her case does not warrant surgery, she lacks a medically determinable impairment capable of producing a disability.

In addition, the ALJ failed to discuss the dosage, effectiveness, and side effects of her medications and her other treatments, such as epidural blocks. (Tr. 322-28, 501, 504-05.) The ALJ also failed discuss the supporting testimony of Eicher's daughter, who saw her everyday and was well-positioned to compare the seriousness of Eicher's symptoms over time. (Tr. 570-74.) This analysis, or lack thereof, tainted the ALJ's determination at step four that Eicher retained the RFC to perform her past relevant work.

To determine a claimant's physical abilities, the ALJ should "first assess the nature and extent of the claimant's physical limitations and then determine the claimant's residual functional capacity for work activity on a regular and continuing basis." 20 C.F.R. § 404.1545(b). The RFC must be based on all relevant evidence in the record. 20 C.F.R. § 404.1545(a)(1); *Young*, 362 F.3d at 1001. Pursuant to Social Security Ruling 96-8p, "The RFC assessment is a function-by-function assessment based upon all the relevant evidence of an individual's ability to do work-related activities. . . ."

The ALJ failed to give a function-by-function analysis of Eicher's past relevant work and to make specific findings regarding the physical requirements of her past relevant work as an officer worker. This failure is significant because the Vocational Expert ("VE") testified that general office work performed in the economy is light work, but as Eicher performed it, the work was sedentary. (Tr. 595-96.) The ALJ's conclusion that Eicher retained the RFC to perform her past relevant work as on office clerk is particularly questionable in light of the fact that office work is classified as light work and per the decision of the ALJ, Eicher retains the RFC for only

sedentary work. (Tr. 27.)

Furthermore, Eicher testified she performed data entry seventy-five percent of the time, and she was currently unable to keyboard because of numbness and pain in her arms and fingers. (Tr. 555-57.) Not only would Eicher's testimony appear to contradict the finding that she could perform her past relevant work, but so would the opinions of Drs. Romain and Chang, who found that Eicher had significant restrictions in her ability to reach, handle and finger. (Tr. 344-49; 497-98.) *See, e.g., Gudgel v. Barnhart*, 345 F.3d 467, 470 (7th Cir.2003) (stating that an administrative law judge can reject an examining physician's opinion only for reasons supported by substantial evidence in the record; a contradictory opinion of a non-examining physician does not, by itself, suffice); *see also Clifford*, 227 F.3d at 872 (noting that an ALJ must build an accurate and logical bridge from the evidence to his conclusion). The ALJ's failure to make specific findings prevents the Court from conducting any meaningful review and this case must be remanded as a result.

V. CONCLUSION

In sum, the ALJ's step four analysis was flawed in several respects. The ALJ improperly evaluated the opinion of Dr. Romain and failed to clarify what weight he assigned to the opinion of Dr. Chang. He also failed to consider all relevant evidence when determining that Eicher's testimony was not credible. Finally, the ALJ failed to develop the record on, and to make the required findings about, the mental and physical demands of plaintiff's past relevant work. Thus, the ALJ's ultimate conclusion that Eicher could return to her past relevant work is necessarily grounded on an incomplete record and insubstantial evidence.

For these reasons, the decision is hereby REVERSED and REMANDED to the

Commissioner¹⁹ for further findings consistent with this opinion. SO ORDERED.

Enter for this 10th day of September, 2004.

s/Roger B. Cosby
Roger B. Cosby,
United States Magistrate Judge

¹⁹The Court is troubled by the comments of the ALJ concerning the competence of Dr. Romain. (Tr. 539, 543, 549.) The ALJ may have improperly discounted Dr. Romain's testimony based on matters clearly outside the record. Accordingly, upon remand, the Agency should consider having a different ALJ conduct any further proceedings in this matter.