

STANDARD OF REVIEW

When reviewing a disability case, the ALJ must follow a five-step sequential decision-making process. Santise v. Schweiker, 676 F.2d 925, 927 (3d Cir. 1982); see 20 C.F.R. §404.1520. Initially, the ALJ ascertains whether the applicant is currently working; if so, the claim is denied. Id. at §404.1520(b). Second, the ALJ determines whether the claimed impairment is “severe” by using medical evidence to establish whether plaintiff’s impairment is of a magnitude sufficient to significantly limit his “physical or mental ability to do basic work activities;” if it is not, the claim is denied. Id. at §404.1520(c). Third, the ALJ decides, again using only medical evidence, whether the impairment equals or exceeds in severity certain impairments described on Appendix 1 of the regulations; if it does, the claimant is automatically awarded disability benefits. Id. at §404.1520(d). Fourth, the ALJ considers whether the applicant has sufficient “residual functional capacity” – defined as that which an individual can still do despite his limitations – to perform his past work; if so, the claim is denied. Id. at §404.1520(c), see Id. at §404.1520(a). Finally, the ALJ adjudicates on the basis of the claimant’s age, education, work experience, and residual functional capacity, whether the applicant can perform any other substantial gainful work within the economy. Id. at §404.1520(f). If the ALJ finds that a claimant is disabled or is not disabled at any point in this process, the review is terminated. Id. at §404.1520(a).

In determining whether a claimant is capable of performing any substantial gainful employment activity, the ALJ must consider four elements of

proof: (1) the objective medical facts or clinical findings; (2) diagnosis of examining physicians; (3) subjective evidence of pain and disability; and (4) the claimant's age, education and work history. Boyd v. Heckler, 704 F.2d 1207, 1210 (11th Cir. 1983).

When reviewing the ALJ's denial of a claimant's application, a reviewing court applies the "substantial evidence" standard. See 42 U.S.C. §405(g); Burns v. Barnhart, 312 F.3d 113 (3d Cir. 2002). "Substantial evidence is 'more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate'." Ventura v. Shalala, 55 F.3d 900, 901 (3d Cir. 1995) (quoting Richardson v. Perales, 402 U.S. 389, 401 (1971)). The court is not "empowered to weigh the evidence or substitute its conclusions for those of the fact-finder." Williams v. Sullivan, 970 F.2d 1178, 1182 (3d Cir. 1992).

PROCEDURAL HISTORY

Bodner filed an application for DIB and SSI on July 10, 2000. Tr. 72-74. The application was denied on October 18, 2000. Tr. 32-41. Bodner did not pursue this application any further. On June 12, 2002, he filed new applications for DIB and SSI. Tr. 75-78, 273-76. He alleged a disability onset date of December 24, 1999, due to alcoholism and depression.¹ Tr. 88. This application was denied on October 16,

1. In making his decision, the ALJ determined that, although Bodner alleged an onset date of December 24, 1999, the denial of his prior application was res judicata on the issue his disability prior to the date his first application was denied. Tr. 23. Bodner does not specifically contest this holding. We find the ALJ did not err in concluding that res judicata prevented consideration of the prior medical evidence. See 20 C.F.R. § 404.957(c)(1); Tobak v. Apfel, 195 F.3d 183, 186 (3d Cir. 1999) (res judicata is properly applied to preclude a subsequent claim for

2002. Tr. 42-45, 278-81. Bodner timely requested a hearing before an ALJ. Tr. 46. The ALJ held a hearing on July 9, 2003, during which Bodner and a vocational expert (“VE”) testified. Tr. 278-332. On August 25, 2003, the ALJ determined that Bodner was not entitled to benefits because he had the residual functional capacity to engage in gainful activity. Tr. 19-29. The ALJ’s decision was affirmed by the Appeals Council on December 4, 2004, Tr. 9, thus making the ALJ’s decision the final decision of the Commissioner. See. 20 C.F.R. §§ 404.981, 416,1481.

FACTS

At the time of the ALJ’s decision, Bodner was 43 years old. Tr. 72. He has a limited 11th grade education. Tr. 293. His prior work history primary consisted of work as a stockman in shipping and receiving at a department store. Tr. 89. The ALJ found the medical evidence demonstrated that Bodner suffers from depression/dysthymia and has a history of functional alcohol abuse with occasional lapses that require sporadic inpatient admissions. He takes no medications to treat his mental illness. The ALJ made a specific finding that Bodner’s alcohol abuse interferes with his need to receive medication to treat his diagnosed depression/dysthymia. Because of this, the ALJ determined that his alcoholism was material to a finding that that he is unable to pursue appropriate treatment for this depression/dysthymia. Tr. 23.

disability benefits where the “same” claimant has filed a previous application based on the “same” issues and where such prior determination has become final by virtue of administrative or judicial action).

The relevant medical evidence² includes an admission to Eagleville Hospital on April 18, 2002, for one month of in-patient alcoholism treatment. Tr. 179-81. Bodner was diagnosed with alcohol and nicotine dependence, narcissistic personality traits, and hypertension. Tr. 180. Although his discharge prognosis was listed as guarded, he was deemed medically and psychiatrically stable. Tr. 181. An initial report by Dr. Larry Fryer dated June 4, 2002, diagnosed Bodner as having depressive disorder, alcoholism and an inflamed liver. His GAF was listed as 55. At the time of the report, Bodner had been sober for three months. No medications were prescribed, but Bodner was enrolled in a drug and alcohol dual diagnosis outpatient program. Tr. 182.

In a follow-up report dated January 27, 2003, Dr. Fryer again diagnosed depressive disorder, alcohol abuse, and inflamed liver, as well as hypertension. Tr. 262. He opined that Bodner showed excellent attendance at his individual and group treatment sessions, was “building clean time,” understood his behavioral triggers, and was dealing with his depression “non-chemically.” Fryer believed that Bodner had been using alcohol in the past as a form of self-medication for his depression. He believed that Bodner was making some progress on his mental health issues, but that progress was hampered by his medical problems, which continued to persist. He believed that Bodner’s prognosis was still guarded. Tr. 263. In another follow-up report dated April 15, 2003, Dr. Fryer made the same diagnoses, found a GAF score

2. Although some of the medical evidence we discuss comes from before October 16, 2002, we include it only as background information to Bodner’s current medical condition.

of 50, and again noted that no medications had been prescribed. Tr. 216.

On July 3, 2003, Dr. Fryer completed a Medical Source Statement listing the same diagnoses and GAF score. Tr. 218. He rated Bodner as “poor” in the categories of being able to: complete a normal workday/workweek, perform at a consistent pace, accept instructions and respond appropriately to criticism from supervisors, and respond appropriately to changes in the work setting. He rated Bodner as “good” in the categories of being able to: remember locations and work like procedures, and travel in unfamiliar places or use public transit. He rated Bodner as “fair” in all other listed categories, including the ability to understand carry out and remember short, simple instructions, understand carry out and remember detailed instructions, maintain attention and concentration, perform activities within a schedule, maintain regular attendance, be punctual, sustain an ordinary routine without supervision, and make simple decisions. Tr. 220-221.

In a report to the state Bureau of Disability Determination dated September 25, 2002, examining psychiatrist Dr. Carl Herman reported that Bodner had twice attempted employment, but could not concentrate and left after two weeks. At the time of the report, Bodner had been sober for five months, was attending twice weekly out patient mental health services at Northeastern Mental Health Services, but was not taking medication for his depression/dysthymic disorder. Dr. Herman reported that Bodner is capable of doing household chores, can shop and take public transit alone, that he attends church and is able to manage his money. He opined that Bodner is accurately oriented, in contact with his environment, has normal range

intelligence, has no evidence of organic brain dysfunction, does quite well with retention, short term memory, and proverb interpretation, was pleasant, cooperative, had no hostility, nor dependence, his affect was appropriate, his mood was only mildly depressed, his thinking was logical, coherent, and relevant without flight of ideas, loosening of associations, delusions or hallucinations, and his judgment was satisfactory. Tr. 185-86. Herman diagnosed dysthymic disorder and alcohol dependence in remission.

Dr. Herman also completed a medical assessment. He rated Bodner as “poor” in the categories of being able to: understand, remember and carry out complex or detailed job instructions, but rated him “good” in his ability to understand, remember and carry out simple job instructions. Tr. 188. He rated Bodner as good or fair in all other categories. Id.

Bodner testified before the ALJ that he has been sober since April 2002. Tr. 298. He sees a therapist twice a month, and attends group therapy eight times a month. Tr. 299. He reported difficulty sleeping, Tr. 301, difficulty with concentration, Tr. 305, 316-17, mood swings during the course of the day, Tr. 312, and problems being around crowds, Tr. 314. He testified he does not take psychotropic medication because Dr. Fryer has concerns about his liver. Tr. 306. He reported that he spends his day watching television or listening to the radio, has no hobbies, does little house or yard work, takes walks, shops for groceries, and goes to group therapy. Tr. 301-304. He claimed to tire easily, have problems with concentration and suffer panic attacks. Tr. 304.

Also testifying at the hearing was Julius Romanoff, a VE. He was asked to assume an individual of Bodner's age, education and past work history, with Dr. Fryer's determination of a poor ability to complete a normal workday/workweek and perform at a consistent pace. He opined that such a person would be unable to perform Bodner's prior work, and would be unable to perform even unskilled work at any exertional level. Tr. 323-24. When asked to assume a person who could perform jobs at all exertional levels that were simple and unskilled, i.e. the limitations found by the examining psychiatrist Dr. Herman, the VE opined that such a person could perform jobs such as assembler, packer and stock clerk. Tr. 325-26. Assuming Dr. Herman's conclusions – difficulties dealing with work stress, maintaining attention and concentration, but able to follow simple instructions – the VE opined that such a person could perform the same types of unskilled work. Tr. 326-27.

The ALJ determined at step three of the five step analysis that Bodner's depression, in combination with his alcoholism, did not meet or equal the criteria of the Listings of Impairments. Tr. 24. At step four, he determined that Bodner did not have the residual functional capacity to return to his prior work. Tr. 27. As step five, the ALJ determined that, although Bodner was unable to perform the full range of heavy work, he retained the residual functional capacity to perform such jobs as assembler, packer, and stock clerk, and thus was not disabled under the Social Security Act. Tr. 28.

DISCUSSION

Bodner argues that the ALJ erred in rejecting the opinion of his treating psychiatrist, Dr. Fryer, that Bodner was unable to complete a normal workday/workweek, perform at a consistent pace, accept instructions and respond appropriately to criticism from supervisors, and respond appropriately to changes in the work setting. Instead, the ALJ accepted the opinion of the examining psychiatrist Dr. Herman, that Bodner was could perform jobs at all exertional levels, so long as they were simple and unskilled.

It is well-settled that a treating physician's opinion deserves great weight because that opinion “reflect[s] expert judgment based on a continuing observation of the patient’s condition over a prolonged period of time.” Plummer v. Apfel, 186 F.3d 422, 429 (3d Cir.1999). The ALJ may only reject the opinion of a treating physician “on the basis of contradictory medical evidence and not due to his or her own credibility judgments, speculation or lay opinion.” Morales v. Apfel, 225 F.3d 310, 317 (3d Cir.2000) (internal quotations omitted). The ALJ may afford a treating physician’s opinion more or less weight depending upon the extent to which supporting explanations are provided. Plummer, 186 F.3d at 429.

In finding that Bodner was not disabled, the ALJ reasoned that Bodner’s alcoholism was “interfering with his need to receive appropriate medications for his depression/dysthymia. As such, he cannot adhere to the mandate of 20 C.F.R., Section 404.1530, reference (sic) his obligation to submit to necessary treatment for his depressive condition.” Tr. 23. The ALJ further concluded that the opinions of

Dr. Fryer regarding Bodner's inability to concentrate, complete the workday, and accept instruction "(this in the absence of palliative medications as would be required by the regulations) thus cannot be given any significant probative value due to such conflict." Tr. 23.

We find that the ALJ was not supported by substantial evidence when he disregarded Dr. Fryer's opinions. Essentially, the ALJ determined that when sober and compliant with properly medicated psychotropic drugs Bodner can sustain basic tasks in spite of his combined psychiatric disorder. This assertion finds no support in the medical record and the ALJ's interpretation of the regulations was erroneous. There was no evidence that Bodner has been non-compliant with prescribed drugs because there was no evidence he has been directed to take psychotropic drugs. It appears from Dr. Fryer's records and Bodner's testimony that psychotropic drugs were not prescribed because of plaintiff's liver disease and other health problems.³

More importantly, the regulation cited by the ALJ, 20 C.F.R. § 404.1530 provides that

- (a) What treatment you must follow. In order to get benefits, you must follow treatment prescribed by your physician if this treatment can restore your ability to work.
- (b) When you do not follow prescribed treatment. If you do not follow the prescribed treatment without a good

3. Fryer stated, albeit somewhat cryptically, that the plaintiff's progress on his mental health issues was "hampered by his medical problems," which the record shows included an inflammation of the liver. Bodner testified to the ALJ that he suffers from Hepatitis B. Tr. 296.

reason, we will not find you disabled or, if you are already receiving benefits, we will stop paying you benefits.

As there is no evidence in the record that Bodner failed to follow prescribed treatment, the ALJ's reliance on § 404.1530 was misplaced, particularly because the ALJ used the regulation improperly to disregard a physician opinion, rather than to determine that the claimant was not disabled due to a failure to follow treatment.

Palliative medications are not *required* by the regulation, neither does it create an "obligation to submit to necessary treatment," as the ALJ intimated. The regulation only requires taking palliatives when they are prescribed as part of the plaintiff's treatment.⁴ In order to make a finding that a claimant has failed to follow prescribed treatment, the ALJ is required to engage in the procedure outlined in Social Security Ruling 82-59. It provides:

SSA may make a determination that an individual has failed to follow prescribed treatment only where all of the following conditions exist:

1. The evidence establishes that the individual's impairment precludes engaging in any substantial gainful activity (SGA) or, in the case of a disabled widow(er) that the impairment meets or equals the Listing of Impairments in Appendix 1 of Regulations No. 4, Subpart P; and
2. The impairment has lasted or is expected to last for 12 continuous months from onset of disability or is expected to result in death; and
3. Treatment which is clearly expected to restore capacity to engage in any SGA (or gainful activity, as appropriate) has been prescribed by a treating source; and
4. The evidence of record discloses that there has been refusal to follow prescribed treatment.

4. In addition, there is nothing in the record to support the conclusion that taking such medications would alone have restored Bodner's ability to engage in substantial gainful employment.

There is nothing in the ALJ's decision to indicate that he followed this procedure. As the ALJ did not follow the ruling, his determination that Bodner's alcoholism "interfer[ed] with his need to receive appropriate medications for his depression/dysthymia" was not supported by substantial evidence. Consequently, the ALJ's conclusion that Dr. Fryer's opinions could not be given any significant probative value "due to such conflict" was also error.⁵

The ALJ's determination that Bodner *should* have been taking psychotropic medication appears to be based on a medical summary allegedly provided by a Dr. Barrett. See Tr. 26 ("Given all of the foregoing, the medical summary provided by Dr. Barrett of the state agency (Ex. 9F and 10F), remains the most credible and probative opinion as to claimant's work capacity). The Barrett medical summary, however, is not part of the administrative record and neither attorney mentions it in the portion of their summary judgment memoranda discussing the content of the medical record. It is therefore, unclear whether the ALJ had some other contradictory medical evidence, simply mislabeled the Herman medical summary, or was relying on his own lay opinion, when he concluded that Bodner's alcoholism, rather than the general state of his health, was material to a finding that he unable to pursue appropriate treatment for his depression. Accordingly, we will remand the matter to the Commissioner to permit the ALJ to correct the record or conduct further proceedings as required.

5. Further, as Dr. Fryer's findings of non-exertional limitations were not credited in the hypothetical to the VE, the ALJ's residual functional capacity determination was also not supported by substantial evidence.

