IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF VIRGINIA
HARRISONBURG DIVISION

JERRY L. RUNION,	)	CASE NO. 5:12CV00126
	)	
Plaintiff,	)	
	)	
v.	)	REPORT AND RECOMMENDATION
	)	
	)	
CAROLYN W. COLVIN,[1]	)	
Acting Commissioner of Social Security,	)	
	)	By: B. Waugh Crigler
Defendant.	)	U. S. Magistrate Judge

This challenge to a final decision of the Commissioner which denied plaintiff's June 30, 2010 protectively-filed applications for a period of disability and disability insurance benefits under the Social Security Act ("Act"), as amended, 42 U.S.C. §§ 416, 423, and 1381, et seq., is before this court under authority of 28 U.S.C. § 636(b)(1)(B) to render to the presiding District Judge a report setting forth appropriate findings, conclusions, and recommendations for the disposition of the case. The questions presented are whether the Commissioner's final decision is supported by substantial evidence, or whether there is good cause to remand the case for further proceedings. 42 U.S.C. § 405(g). For the reasons that follow, the undersigned will RECOMMEND that an Order enter DENYING the Commissioner's motion for summary judgment, GRANTING, in part, the plaintiff's motion for summary judgment, and REMANDING this case to the Commissioner for further proceedings.

[1] Carolyn W. Colvin became the Acting Commissioner of Social Security on February 14, 2013. Pursuant to Rule 25(d) of the Federal Rules of Civil Procedure, Carolyn W. Colvin hereby is substituted for Michael J. Astrue as the defendant in this action.

In a decision dated October 26, 2011, an Administrative Law Judge ("Law Judge") found that plaintiff had not engaged in substantial gainful activity since January 1, 2004, his alleged date of disability onset.[2] (R. 16.) The Law Judge found that plaintiff met the insured status requirements for a period of disability and disability insurance benefits through September 30, 2007. (20 C.F.R. § 404.131, R. 16.) The Law Judge determined that plaintiff's history of alcohol abuse, history of pancreatitis, diabetes mellitus, dysthymia, hypothyroidism, hypertension, and back disorder were medically determinable impairments, but were not severe impairments. (R. 16.) The Law Judge thus found plaintiff not disabled under the Act.

The Law Judge also made an alternative finding that, even if plaintiff did have severe impairments, plaintiff's condition did not meet a listing. (R. 23.) The Law Judge further found that plaintiff could perform the full range of medium work and thus retained the capacity to perform his past relevant work as a maintenance mechanic, exterminator, or truck servicer. (R. 24.) The Law Judge reiterated that, even with his alternative findings, plaintiff was not disabled under the Act.

Plaintiff appealed the Law Judge's October 26, 2011 decision to the Appeals Council. (R. 6-13.) In its March 26, 2012 decision, the Appeals Council denied review and adopted the Law Judge's decision as the final decision of the Commissioner. (R. 6.) Due to the death of plaintiff's former counsel, plaintiff's current counsel requested and received an extension of time within which to file an appeal to this court. (R. 1-5.) This action ensued, cross motions for

[2] Disability is defined as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment or combination of impairments that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months. 42 U.S.C. § 1382c(a)(3)(A). In order to qualify for a period of disability and disability insurance benefits, plaintiff must establish that he became disabled prior to the expiration of his insured status, which was September 30, 2007. *See* 20 C.F.R. § 404.131(a); (R. 16.)

summary judgment were filed together with supporting briefs, and oral argument was held by telephone before the undersigned on July 11, 2013.

The Commissioner is charged with evaluating the medical evidence and assessing symptoms, signs, and medical findings to determine the functional capacity of the claimant. *Hays v. Sullivan*, 907 F.2d 1453, 1456 (4th Cir. 1990); *Shively v. Heckler*, 739 F.2d 987 (4th Cir. 1984). The regulations grant some latitude to the Commissioner in resolving conflicts or inconsistencies in the evidence, which the court is to review for clear error or lack of substantial evidentiary support. *Craig v. Chater*, 76 F.3d 585, 589-590 (4th Cir. 1996). In all, if the Commissioner's resolution of the conflicts in the evidence is supported by substantial evidence, the court is to affirm the Commissioner's final decision. *Laws v. Celebrezze*, 368 F.2d 640, 642 (4th Cir. 1966). Substantial evidence is defined as evidence, "which a reasoning mind would accept as sufficient to support a particular conclusion. It consists of more than a mere scintilla of evidence but may be somewhat less than preponderance." *Id.* at 642.

Plaintiff seeks reversal or remand on two grounds. First, he challenges the Law Judge's finding that he did not suffer any severe impairment. Second, he argues that the Law Judge did not adequately consider the effects of his alcohol-induced dementia. Plaintiff asserts that the Law Judge's decision as adopted by the Commissioner is not supported by substantial evidence.

Plaintiff must show that he was disabled between January 1, 2004, his alleged disability onset date, and September 30, 2007, his date last insured. Plaintiff's earliest medical record is from January 15, 2004, when he was seen by Martin Albert, MD, at the Harrisonburg VA clinic ("VA clinic"). Plaintiff reported at that time that he previously had been taking Effexor for depression, but had to stop due to a lack of insurance. (R. 814.) Dr. Martin diagnosed plaintiff with chronic alcoholism, malnutrition secondary to the above, likely alcoholic hepatitis, history

of right cataract, nicotine habituation, depression, and situational stress. (R. 814-815.) Dr. Martin noted plaintiff would likely require cataract surgery and recommended that plaintiff undergo detoxification at the Martinsburg VA Hospital ("VA Hospital"). (R. 815.)

Plaintiff reported to the VA Hospital on January 21, 2004, requesting detoxification and a consult for his eye cataract. (R. 813.) Plaintiff was diagnosed with acute alcohol intoxication, alcohol withdrawal, and alcohol dependence, and was admitted for detoxification. (R. 810.) Plaintiff continued to have tremors the following evening and Ativan was prescribed. (R. 797.) By January 23, plaintiff was more tremulous and his roommates reported that he had been talking to the floor, although plaintiff denied hallucinations. (R. 793.) Plaintiff was diagnosed with protracted withdrawal with early hallucinosis. (*Id.*) Plaintiff reported that he "had to walk like a duck" to keep his balance and had lumbar pain. (R. 788, 790.) Plaintiff's progress notes reported assessing plaintiff as having ineffective individual coping and that he has refused rehabilitation, insisting that he could stop drinking on his own. (R. 767-810.) Plaintiff was discharged from the VA Hospital on January 29, 2004, with instructions to attend his scheduled appointments. (R. 767-768.)

Plaintiff followed up at the VA Clinic on February 29, 2004, complaining of sharp pain in the small of his back. (R. 767.) Plaintiff reported that he had a couple of beers and had not been attending AA meetings, but he did not believe this was a problem. (R. 766.) On March 29, 2004, plaintiff was diagnosed with anemia and hypothyroidism. (R. 759.) On April 6, 2004, plaintiff underwent cataract surgery on his right eye. (R. 754.) On April 12, 2004, plaintiff presented for a urology consult with Prashant Mehta, MD, who advised that plaintiff undergo a cystoscopy which he refused. Dr. Mehta also recommended that plaintiff stop drinking and smoking, but noted he was unlikely to do so. (R. 749.) On April 21, 2004, plaintiff followed up

with Barbara Fenton, MD, at the VA Clinic. Dr. Fenton diagnosed plaintiff as suffering anemia, hypothyroidism, recent cataract surgery, borderline elevated A1C with no history of diabetes, and nicotine habituation. (R. 744-745.) Dr. Fenton noted that plaintiff continued to drink four to five beers and smoke a pack each day with no interest in changing his habits. (R. 745.) On August 2, 2004, plaintiff reported that he was drinking up to twelve beers a day, but that he did not want help because he denied he had a problem with alcoholism. (R. 740.) On April 20, 2005, plaintiff informed personnel at the VA clinic that he had been seen at Augusta Medical Center (AMC) for pain in his left leg and knee which had been diagnosed as sciatica pain. (R. 735.) He complained of ongoing numbness from his knee to his foot. (*Id.*)

On July 28, 2005, plaintiff was admitted to AMC due to complaints of abdominal pain. Plaintiff reported that he last drank alcohol three days earlier. (R. 386.) Plaintiff was diagnosed with acute pancreatitis likely secondary to alcohol, dehydration, leukocytosis, impaired glucose tolerance without known history of diabetes, history of hypothyroidism with unknown recent control, alcohol use, tobacco use, chronic macrocytosis, chronic back pain, chronic hypertension, and hypomagnesaemia/hypokalemia. (R. 388.) Plaintiff was anxious to be discharged so that he did not miss a scheduled appointment at the VA Hospital. (*Id.*) Plaintiff was treated for alcohol withdrawal with Ativan and then with Librium. (R. 390.) Plaintiff's pancreatitis was treated with aggressive hydration as well as thiamine, multivitamin, folate, and a proton pump inhibitor, and plaintiff was discharged on August 1, 2005. (*Id.*) Plaintiff reported to the VA Clinic on August 8, 2005, reporting that he had been placed on insulin while in the hospital but had been discharged without any diabetic medications. (R. 731.) Plaintiff was instructed on checking his blood sugar level and was prescribed Metformin. (*Id.*)

On August 22, 2005, plaintiff was seen at the VA clinic for a routine appointment. (R. 727.) Plaintiff reported that he was no longer drinking alcohol and requested Zoloft, as he believed his Trazadone was ineffective. (R. 727.) On September 26, 2005, plaintiff continued to report that he was not consuming alcohol, and stated that he believed the Zoloft had helped with his depression. (R. 724.) Plaintiff was diagnosed with pancreatitis, diabetes mellitus type 2, hypothyroidism, recent cataract surgery, hyperlipidemia, nicotine habituation, degenerative joint disease, and B-12 deficiency anemia. (R. 726.)

On January 30, 2006, plaintiff reported to the VA clinic, complaining of stomach pains after having consumed a twelve-pack of beer over the weekend. (R. 716.) Plaintiff also reported difficulty voiding, which the doctor felt may have been caused by spinal stenosis. (R. 719.) Plaintiff was originally sent home, but due to elevated creatinine, he was instructed to go to the ER immediately. (R. 714.) Plaintiff was admitted to the ICU at the VA Hospital for acute renal failure. (R. 702.) Plaintiff remained at the VA Hospital until February 8, 2006, when he was discharged with instructions to follow up with his primary care physician and with nephrology. (R. 648.) On February 13, 2006, plaintiff followed up at the VA Clinic. Plaintiff's doctor noted at that time that "he has very poor insight into his medical condition." (R. 644.) On February 27, 2006, plaintiff received instruction from the VA clinic on insulin shots. (R. 642.) On March 6, 2006, plaintiff followed up with nephrology, who noted that plaintiff was back at his baseline and prescribed Losartan, with instructions to follow up in six months. (R. 639.)

On April 26, 2006, plaintiff was admitted to AMC complaining of abdominal pain. Plaintiff reported that he had started consuming alcohol approximately two weeks prior but had stopped about four or five days before admission. (R. 249.) On April 27, Michael Barrett, MD, reported that plaintiff "was markedly agitated, I believe delirious requiring 4-point restraints and

large amounts of benzodiazepines." (R. 255.) Dr. Barrett believed that plaintiff sincerely wanted to quit alcohol and had made good strides. (*Id.*) Dr. Barrett discharged plaintiff on April 29, 2006 at plaintiff's request. On June 16, 2006, plaintiff was treated in the ER at AMC for abdominal pain and alcohol withdrawal. (R. 259.)

On July 10, 2006, plaintiff was transported to AMC after being found unresponsive in his home. (R. 260.) While in the ER, plaintiff exhibited "some withdrawal behavior, including misperceptions of insects in the room." (R. 261.) Plaintiff was admitted to the ICU with a diagnosis of acute renal failure, alcoholic hepatitis, anemia, and alcohol withdrawal. (R. 261, 265.) John Cramer, MD, diagnosed plaintiff with dementia secondary to chronic alcoholism and organic brain disease possibly due to Wernicke encephalopathy,[3] among other diagnoses, and opined that he "was not a good candidate to go back home due to his obvious dementia." (R. 267-268.) A CT scan of plaintiff's head taken on July 11, 2006, indicated that although there were no high-density lesions, there was cortical sulci prominence with mild ventricular enlargement consistent with generalized cerebral atrophy. (R. 335.) Plaintiff was confused as to the name of the hospital, and was unaware of the year or the date. (R. 268.) Dr. Cramer opined that plaintiff's mental status might improve at most another 10%, and, on July 26, 2006, he had plaintiff transferred directly to the VA hospital for further rehabilitation and treatment of his alcoholism. (*Id.*)

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[3] Wernicke's encephalopathy is an acute neuropsychiatric disorder commonly associated with alcohol abuse. The chronic form of the disorder is "characterized by a memory disorder, appearing in clear consciousness, such that the patients appear to be entirely in possession of their faculties." Individuals often create false recollections which are real memories recalled out of temporal sequence. Early treatment with thiamine is necessary to prevent structural brain lesions. Allan D. Thomson, Irene Guerrini & E. Jane Marshall, *Wernicke's Encephalopathy: The Role of Thiamine*, PRACTICAL GASTROENTEROLOGY 21 (June 2009), *available at* http://www.medicine.virginia.edu/clinical/departments/medicine/divisions/digestive-health/nutrition-support-team/nutrition-articles/ThomsonArticle.pdf.

Plaintiff was seen for evaluation on July 27, 2006, by both physical therapy and occupational therapy at the VA Hospital. Stephanie O'Connor, MPT, noted that plaintiff presented with "a forward head and posterior pelvic tilt while walking," but plaintiff did not want to receive physical therapy. (R. 617.) Kristen Wingate, an occupational therapist, opined that plaintiff was oriented times three, but had diminished insight into his deficits. (R. 615.) Ms. Wingate did not believe plaintiff would benefit from occupational therapy. (*Id.*) Plaintiff was discharged from both physical therapy and occupational therapy without receiving further services. (R. 616-617.) On August 1, 2006, plaintiff was evaluated by Gwinnella McBride, a social worker. Ms. McBride opined that "based on medical and social needs [plaintiff] requires long term care where his needs can be met by staff in a safe, clean and supportive environment." (R. 610.) However, plaintiff was not interested in participating in a substance abuse program. (R. 609.) Plaintiff was discharged from the VA Hospital on August 8, 2006. (R. 598.)

Plaintiff followed up with Jennifer Sargent, MD, at the VA Clinic on August 14, 2006. Dr. Sargent advised plaintiff to continue his medications and recommended a psychiatric consult regarding detoxification. (R. 590.) On September 18, 2006, plaintiff was seen at the VA clinic for a routine appointment due to his diabetes. (R. 574.) On October 25, 2006, plaintiff was seen by nephrology, who advised plaintiff to continue his current medications. (R. 570.) On November 22, 2006, plaintiff was evaluated for participation in the VA's home telehealth program so that his diabetes and hypertension could be more closely monitored. (R. 567.) On January 12, 2007, plaintiff saw Dr. Gerald Brown, a psychiatrist, for an initial consultation. Dr. Brown diagnosed plaintiff with a history of ethanol dependence, dysthymia, and insomnia. (R. 541.) Dr. Brown recommended that plaintiff continue taking Sertraline and Trazadone. (*Id.*)

On February 28, 2007, plaintiff was admitted to AMC after complaining of abdominal pain. (R. 269.) Plaintiff was noted to be a very poor historian and his medical records had to be reviewed. (*Id.*) Plaintiff did report that he had recently resumed drinking four or five mixed drinks a day. (*Id.*) Plaintiff improved with treatment and reported that he was committed to stopping his alcoholism, but refused a referral for an alcohol cessation program. (R. 275.) On March 6, 2007, plaintiff was discharged with a diagnosis of acute alcoholic pancreatitis, alcoholism with a history of withdrawal syndrome and Wernicke encephalopathy, insulin-dependent diabetes mellitus, chronic macrocytic anemia, acute drop in hematocrit during hospital stay without clear cause or obvious bleeding, hypothyroidism, tobacco addiction, and hypertension. (*Id.*)

On March 9, 2007, plaintiff followed up with Kafui Tsikata, MD, at the VA Clinic. (R. 521.) Plaintiff reported at this visit that his blood sugars were under better control and requested a prescription for Antabuse to assist with his alcohol cessation. (R. 521.) On March 14, 2007, plaintiff reported high blood sugar levels and felt that "he really feels he needs some education about his meals." (R. 519.) On April 2, 2007, plaintiff reported to Dr. Brown at a psychiatric appointment that he had been sober for at least three months. (R. 515.) Dr. Brown instructed plaintiff to continue his current medications but did not prescribe Antabuse because of plaintiff's kidney problems and his diabetes. (*Id.*) On June 4, 2007, plaintiff was seen by a nutritionist regarding his poorly controlled diabetes mellitus. (R. 1162.) Despite having stated previously that he would like more education, plaintiff "wonder[ed] why he was scheduled for nutrition" and "indicate[d] he plans to eat whatever he pleases." (*Id.*)

On June 19, 2007, plaintiff was seen in the ER at AMC in an altered mental state. (R. 285.) Plaintiff was administered glucose and discharged with a diagnosis of suffering a

hypoglycemic event, diabetes, and tobacco addiction. (R. 286.) On August 27, 2007, plaintiff followed up with Dr. Tsikata at the VA Clinic. Plaintiff reported that he had not needed to take insulin in over a month because his blood sugar levels were appropriate. (R. 1143.) Plaintiff's insured status expired on September 30, 2007.

The Law Judge found that the plaintiff had no severe impairments and that, alternatively, he could perform the full range of medium work. Plaintiff first contends that the Law Judge erred in finding that his dementia due to Wernicke's encephalopathy was not a severe impairment. Plaintiff was diagnosed with dementia in 2006, well before the expiration of his insured status. The Law Judge did not discuss plaintiff's dementia in his decision, although he noted that he considered the opinions of the state physicians regarding plaintiff's mental status. (R. 22.) Those physicians indicate that plaintiff was not impaired due to his depression. (R. 89, 99.) On the other hand, John Cramer, M.D., a treating physician who initially diagnosed plaintiff with dementia, did not believe that he should even be living on his own. (R. 268.) Given this assessment, the Law Judge was required to explain why he disregarded Dr. Cramer's diagnosis of dementia.

The Commissioner argues that the Law Judge relied on the state physician's assessment which pointed out that plaintiff was not referred to a neurologist and that his CT scan showed only mild ventricular enlargement. This assessment fails to recognize that Dr. Cramer discharged plaintiff directly to another inpatient facility, that plaintiff already was taking thiamine, which apparently is the only treatment for Wernicke's encephalopathy, and that a CT scan was not considered adequate to rule out Wernicke's encephalopathy.[4] Even if the rationale offered here by the Commissioner is accurate, which the court should not decide on the record

[4] *See* E. Antunez, *et al*., *Usefulness of CT and MR Imaging in the Diagnosis of Acute Wernicke's Encephalopathy*, AM. J. ROENTGENOLOGY 1131 (Oct. 1998). Indeed, Dr. Cramer's own diagnosis was made after the results of plaintiff's CT scan. (R. 268, 335.)

before it, the Law Judge still was required to give an explanation why the treating source diagnosis was rejected. Here, the Law Judge does not even acknowledge that plaintiff was diagnosed with dementia, which is a medically determinable impairment. Under these circumstances, good cause exists to remand this case to the Commissioner make findings concerning why the treating source diagnosis should not be given controlling weight and whether plaintiff's dementia due to Wernicke's encephalopathy is a severe impairment.

Plaintiff next argues that the Law Judge's other credibility findings are not supported by substantial evidence. Plaintiff takes the position that because the Law Judge failed to adequately consider his mental state, his credibility findings are fundamentally flawed. In particular, the Law Judge explicitly relies on what he believed were inconsistencies in the plaintiff's statements to treatment providers concerning, among other things, his tobacco and alcohol use, and inaccuracies in time frames surrounding his use of alcohol. (R. 21.)

It is true that, throughout the relevant period, plaintiff frequently misreported time frames for his alcohol use as well as the occasions when he was treated. However, plaintiff argues that this is a symptom consistent with dementia due to Wernicke's encephalopathy, and that it supports, rather than undermines, his credibility. Moreover, plaintiff points out that his medical providers almost universally noted that plaintiff exhibited extremely poor insight into his medical condition. He argues that his mental status prevented him from complying with instructions and that the Law Judge essentially never reconciled these facts in his decision.

As to the severity of plaintiff's physical symptoms, the Law Judge found that plaintiff received only routine and conservative treatment for his back and other orthopedic impairments, and that surgery never was recommended or performed. (R. 21.) While the Law Judge is correct

that plaintiff did not undergo back surgery prior to his date last insured,[5] he was referred to neurosurgery as early as January of 2006, and has complained of back pain since 2004. (R. 719.)

The trouble the undersigned has here is that the Law Judge's finding that plaintiff did not suffer severe impairments is at odds with the evidence of every physician of the record, including the State agency review physicians, who believed that plaintiff's suffered severe physical impairments, though they were not disabling. (R. 83.) In other words, only the Law Judge was of the view that plaintiff's impairments were not severe. Because that determination carried the Law Judge into an area over which he had no expertise, his finding in this respect is not supported by substantial evidence.

The Law Judge also discredited plaintiff's claims on the ground that he did not file his claim for disability for over five years after his alleged date of disability onset. (R. 22.) The undersigned has never seen or heard of such a thing. There are many reasons a claimant may not seek benefits at the earliest possible date, and to attribute the absence of severity to the timing of a claimant's application is speculative at best and plainly erroneous at worst. In neither case can it be justified as supported by the substantial evidence.

Finally, plaintiff argues that the Law Judge erred in finding that plaintiff's substance abuse would preclude a finding of disability. (R. 14.) The difficulty in addressing this argument here is that the Law Judge never reached a point in the process where plaintiff was found disabled so that a determination of the contributing nature of his alcohol use could be made. 20 C.F.R. §§404.1535 and 1536. Moreover, the finding in this case came in the first page of the

[5] Plaintiff underwent multiple back surgeries following his date last insured. (*See* R. 1383.)

decision, before the Law Judge had even assessed the evidence. (R. 14.) This issue should be revisited on remand in the event the Commissioner finds plaintiff otherwise disabled.[6]

There also is a procedural aspect of this case that troubles the undersigned, though it was not raised by the plaintiff. The Law Judge, after finding that plaintiff had no severe impairments, engaged in alternate findings in the event plaintiff's impairments could be considered severe. (R. 23-25.) The regulations make it clear that, if a claimant is found not disabled at any stage of the five-step sequential process, "we do not go on to the next step." 20 C. F. R. § 404.1520 (a)(4). Only if "we cannot find you are disabled or not disabled at a step [can] we go on to the next step." *Id.* This procedure allows for meaningful judicial review of the findings the Commissioner may have adopted. The undersigned does not believe the regulations give a Law Judge or the Commissioner the leeway to make the alternative findings that are present in this case. In the words of Homer Stokes in *O Brother, Where Art Thou*, "You either 'Is' or you 'Ain't....'"[7]

In summary, the myriad of procedural defects in the adjudication of the claim as well as the lack of substantial evidentiary support for some of the Law Judge's findings call for the case to be remanded. For all these reasons, it is RECOMMENDED that an Order enter DENYING the Commissioner's motion for summary judgment, GRANTING, in part, the plaintiff's motion for summary judgment, and REMANDING this case to the Commissioner for further proceedings.

The Clerk is directed to immediately transmit the record in this case to the presiding United States District Judge. Both sides are reminded that pursuant to Rule 72(b), they are entitled to note objections, if any they may have, to this Report and Recommendation within fourteen (14) days hereof. Any adjudication of fact or conclusion of law rendered herein by the

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[6] This may be a difficult task in that the diagnosis of plaintiff's dementia arose during a period of sobriety. For example, plaintiff had been hospitalized and thus unquestionably sober for over two weeks when he was unaware of the year and his location. (R. 268.)

[7] O BROTHER, WHERE ART THOU? (Touchstone Pictures 2000).

undersigned not specifically objected to within the period prescribed by law may become conclusive upon the parties. Failure to file specific objections pursuant to 28 U.S.C. § 636(b)(l)(C) as to factual recitations or findings as well as to the conclusions reached by the undersigned may be construed by any reviewing court as a waiver of such objection. The Clerk is directed to transmit a certified copy of this Report and Recommendation to all counsel of record.

ENTERED: B. Waugh Crigler
U.S. Magistrate Judge

September 17, 2013
Date