

IN THE UNITED STATES DISTRICT COURT  
FOR THE WESTERN DISTRICT OF VIRGINIA  
Danville Division

ANITA RENEE DOUGLAS,	)	
Plaintiff,	)	
	)	Civil Action No. 4:15-cv-27
v.	)	
	)	<u>REPORT AND RECOMMENDATION</u>
COMMISSIONER	)	
OF SOCIAL SECURITY,	)	By: Joel C. Hoppe
Defendant.	)	United States Magistrate Judge

Plaintiff Anita Renee Douglas, proceeding *pro se*, asks this Court to review the Commissioner of Social Security’s (“Commissioner”) final decision denying her applications for disability insurance benefits (“DIB”) and supplemental security income (“SSI”) under Titles II and XVI of the Social Security Act (the “Act”), 42 U.S.C. §§ 401–434, 1381–1383f. The case is before me by referral under 28 U.S.C. § 636(b)(1)(B). ECF No. 8. Having considered the administrative record, the parties’ briefs, and the applicable law, I find that substantial evidence supports the Commissioner’s decision that Douglas is not disabled. Therefore, I recommend that the Court **GRANT** the Commissioner’s Motion for Summary Judgment, ECF No. 15, and **AFFIRM** the Commissioner’s final decision.

I. Standard of Review

The Social Security Act authorizes this Court to review the Commissioner’s final decision that a person is not entitled to disability benefits. *See* 42 U.S.C. § 405(g); *Hines v. Barnhart*, 453 F.3d 559, 561 (4th Cir. 2006). The Court’s role, however, is limited—it may not “reweigh conflicting evidence, make credibility determinations, or substitute [its] judgment” for that of agency officials. *Hancock v. Astrue*, 667 F.3d 470, 472 (4th Cir. 2012). Instead, the Court asks only whether the Administrative Law Judge (“ALJ”) applied the correct legal standards and

whether substantial evidence supports the ALJ's factual findings. *Meyer v. Astrue*, 662 F.3d 700, 704 (4th Cir. 2011).

“Substantial evidence” means “such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.” *Richardson v. Perales*, 402 U.S. 389, 401 (1971). It is “more than a mere scintilla” of evidence, *id.*, but not necessarily “a large or considerable amount of evidence,” *Pierce v. Underwood*, 487 U.S. 552, 565 (1988). Substantial evidence review takes into account the entire record, and not just the evidence cited by the ALJ. *See Universal Camera Corp. v. NLRB*, 340 U.S. 474, 487–89 (1951); *Gordon v. Schweiker*, 725 F.2d 231, 236 (4th Cir. 1984). Ultimately, this Court must affirm the ALJ's factual findings if “conflicting evidence allows reasonable minds to differ as to whether a claimant is disabled.” *Johnson v. Barnhart*, 434 F.3d 650, 653 (4th Cir. 2005) (per curiam) (quoting *Craig v. Chater*, 76 F.3d 585, 589 (4th Cir. 1996)). However, “[a] factual finding by the ALJ is not binding if it was reached by means of an improper standard or misapplication of the law.” *Coffman v. Bowen*, 829 F.2d 514, 517 (4th Cir. 1987).

A person is “disabled” if he or she is unable to engage in “any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.” 42 U.S.C. §§ 423(d)(1)(A), 1382c(a)(3)(A); 20 C.F.R. §§ 404.1505(a), 416.905(a). Social Security ALJs follow a five-step process to determine whether an applicant is disabled. The ALJ asks, in sequence, whether the applicant (1) is working; (2) has a severe impairment; (3) has an impairment that meets or equals an impairment listed in the Act's regulations; (4) can return to his or her past relevant work based on his or her residual functional capacity; and, if not (5) whether he or she can perform other work *See Heckler v. Campbell*, 461

U.S. 458, 460–62 (1983); 20 C.F.R. §§ 404.1520(a)(4), 416.920(a)(4). The applicant bears the burden of proof at steps one through four. *Hancock*, 667 F.3d at 472. At step five, the burden shifts to the agency to prove that the applicant is not disabled. *See id.*

## II. Procedural History

Douglas applied for DIB and SSI on August 23, 2013, Administrative Record (“R.”) 213–19, 220–28, ECF No. 11, alleging disability caused by deteriorating and bulging discs, R. 253. She claimed disability onset of April 1, 2013, at which time she was forty-six years old. She previously worked as an emergency services dispatcher, office clerk, admissions counselor, childcare provider, and insurance agent. R. 220, 254, 277–80. Disability Determination Services (“DDS”), the state agency, denied her claim at the initial and reconsideration stages. R. 90–123. On December 9, 2014, Douglas appeared with counsel at an administrative hearing before an ALJ. R. 40–77. Douglas testified at the hearing, as did a vocational expert (“VE”).

The ALJ denied Douglas’s claim in a written decision issued on December 17, 2014. R. 19–34. He found that Douglas had severe impairments of myalgias, hypertension, and obesity, but found her other impairments of fibroids, right eye glaucoma, depression, rectal bleeding, constipation, and abdominal pain to be nonsevere. R. 21–23. The ALJ then determined that none of Douglas’s impairments, alone or in combination, met or medically equaled the severity of a listed impairment. R. 23–25. The ALJ specifically considered Listing 1.00Q and SSR 02-1p for obesity, Listing 1.02 for major dysfunction of a joint, and Listing 4.04 for ischemic heart disease. R. 23–24. He also considered Douglas’s fibromyalgia-type symptoms under SSR 12-2p. R. 24. As to Douglas’s residual functional capacity (“RFC”), the ALJ determined that she could perform light work,<sup>1</sup> with some postural and environmental limitations. R. 21–28. Based on this

---

<sup>1</sup> “Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds.” 20 C.F.R. §§ 404.1567(a), 416.967(a). A person who can meet these

RFC and the testimony of the VE, the ALJ concluded that Douglas could perform her past relevant work as an insurance agent, teacher's aide, dispatcher, and office clerk as actually and normally performed. R. 33–34. The ALJ therefore concluded that Douglas was not disabled. R. 34. The Appeals Council declined Douglas's request for review. R. 1–3. This appeal followed.

### III. Discussion

#### A. *Statement of Facts*

##### 1. *Medical Evidence*

On January 7, 2011, Douglas was involved in a car accident, after which she complained of pain in her back, neck, arms, and legs. R. 337. Images taken of Douglas's cervical and lumbar spine were unremarkable. R. 326, 328. Examination of her cervical and lumbar spine in January showed some decrease in range of motion, as well as pain, swelling, and muscle spasm upon palpation, R. 339, but testing in February and March was normal, R. 341, 343. During the same period, exams of Douglas's lower back showed pain upon range of motion testing and pain, muscle spasm, and swelling upon palpation, but a normal gait. R. 340, 342, 344–45. By May, exam findings of her lower back were normal, R. 346, and John M. Hoffman, D.C., authorized Douglas to return to regular duty work with no restrictions, R. 359.

On September 12, 2013, Douglas visited Michael Torres, M.D., and complained of back, left leg, and right shoulder pain. R. 388–89. She reported having sustained injuries in three motor vehicle accidents in the past two years and when she grabbed a moving wheelchair on a school bus four months prior. Dr. Torres noted that Douglas was obese and had full range of motion in her right shoulder, some tenderness in the paraspinal areas, negative straight leg raising tests, full range of motion of hips and knees, and no signs of joint pain or inflammation. He diagnosed

---

lifting requirements can perform light work only if he can also “do a good deal of walking or standing, or do some pushing and pulling of arm or leg controls while sitting.” *Hays v. Sullivan*, 907 F.2d 1453, 1455 n.1 (4th Cir. 1999).

shoulder and lumbar strain, prescribed naproxen, and ordered physical therapy evaluation and imaging of her back. Dr. Torres also emphasized that Douglas should adhere to a low salt, low fat, limited starch, and high fiber diet while also avoiding sweet liquids and sugars. Imaging taken the following day of Douglas's lumbar spine showed "slight" scoliosis; no compression deformity, spondylolysis, or spondylolisthesis; mild facet joint arthropathy; and minimal degenerative disc disease for Douglas's age. R. 382. On September 17, Dr. Torres referred Douglas to physical therapy for her back, left leg, and right shoulder problems. R. 373. Douglas complained that physical therapy had not helped her in the past and naproxen was not relieving her pain, and she requested Flexeril. R. 386. Douglas explained that she had taken her mother's Flexeril, and it had made her pain better. R. 384. During the next three appointments through October 1, Dr. Torres's findings on exam remained normal, including normal strength in all extremities and normal gait. R. 384–85, 387.

On October 5, Maria A. Ibarra, M.D., examined Douglas regarding her complaints of back pain. R. 400–01. Dr. Ibarra found some tenderness, but no swelling, edema, or erythema of the tissue around her spine and no spasm or decreased strength. Douglas requested a Toradol injection, which Dr. Ibarra administered. On October 10, Douglas told Gregory Alba, M.D., that the injection temporarily relieved her pain, but that the pain had returned. R. 501–02. On exam, Dr. Alba found pain upon movement and paraspinous muscle spasms, but no swelling or deformities. Douglas weighed 189 pounds and had a body mass index ("BMI") of 34. Dr. Alba noted that she was taking Flexeril and ibuprofen.

On October 15, Victor Owusu-Yaw, M.D., of Danville Neurology Associates, Inc., conducted a new patient exam of Douglas. R. 462–68. Douglas reported having chronic back, neck, and extremities pain since the 1990s and numbness and tingling in her feet and hands.

Douglas also reported becoming easily irritated and experiencing depression, anxiety, and memory loss. On physical examination, Dr. Owusu-Yaw noted that Douglas appeared comfortable and in no distress. She had full range of motion in her upper and lower extremities and had no clubbing, cyanosis, or edema. Douglas had full strength and mostly normal reflexes and sensation. Her coordination was normal, and although she was unable to walk on her heels and toes or perform tandem walking, she needed no assistance in ambulating. Mental status exam was normal with no evidence of concentration or memory problems or disorientation. Dr. Owusu-Yaw diagnosed unspecified myalgia and myositis, limb pain, unspecified neuralgia or neuritis, and other chronic pain. He prescribed Cymbalta and noted that Douglas was taking ibuprofen and naproxen. Exam findings on October 29 were again normal, and Dr. Owusu-Yaw noted that a nerve conduction test of Douglas's lower extremities was normal. R. 469–71. On December 16, Douglas complained of muscle pain and numbness. Dr. Owusu-Yaw made the same findings on exam and prescribed an increased dose of Cymbalta. R. 477–79.

Vinitkumar R. Jalandhara, M.D., examined Douglas on December 5 and found that she had no recent or remote memory impairment, normal attention span and ability to concentrate, and normal coordination, sensation, and reflexes. R. 499–500. Another mental exam on February 17, 2014, was normal. R. 494–95.

On April 1, Douglas was seen for complaints of chest pain and irregular heartbeat that she reported experiencing for the past month. R. 539–42. She also reported shortness of breath with activity. Her cardiovascular exam was normal, and an EKG showed no ischemia. Douglas denied having joint pain or swelling, loss of range of motion, unsteady gait, and any psychiatric symptoms, and Bosh G. Zakhary, M.D., noted that she had lower extremity edema. Dr. Zakhary reported that Douglas's blood pressure was well controlled, and he scheduled a stress test. He

counseled Douglas on the risks of obesity and the need for weight loss, and he encouraged her to exercise five days a week for forty-five minutes each day. Douglas's stress test was deemed submaximal because it lasted only "1:20 minutes"; thus, its results were inconclusive. R. 544.

On April 2, Douglas had a clinical evaluation with Vivian Andrews, L.P.C., for depression and anxiety. R. 616–24. Mental status exam noted increased anxiety, decreased energy level, and fluctuating sleep pattern, but no other signs or symptoms. Douglas reported feeling depressed because of pain and because she could not do things she used to do. She also reported that she took her father's gabapentin and felt better. On April 30, Ms. Andrews noted that Douglas was doing much better. R. 625–26. Douglas said she was acting as the main pastor in her church that week while the regular pastor was on vacation and she was ministering at the jail. She was hoping to get a job at The Grille, which was identified as a place where people with illnesses could work, and she was considering opening a daycare with her daughter. Douglas said she had been working hard in physical therapy.

On April 14, Douglas told Dr. Owusu-Yaw that she was experiencing pain and numbness in various places in her body, including her hands and feet. R. 636–37. She said her medications were "ok." Dr. Owusu-Yaw noted the same normal findings on physical and mental examination, including that Douglas could walk without assistance.

On April 28, Douglas complained of having trouble walking and requested a walker with a seat. R. 605–06. On examination, Dr. Jalandhara found normal gait, coordination, reflexes, joint range of motion, and extremity strength. He referred Douglas to physical therapy for mobility assessment to determine whether she required a walker. During an initial evaluation, the physical therapist noted that Douglas had minimal to no antalgic gait, no balance deficit, and mostly full extremity strength. R. 583–85. The physical therapist assessed a soft tissue

dysfunction and scheduled Douglas for four weeks of therapy. Additionally, the physical therapist determined that Douglas's level of functioning did not require a walker with a seat, and he provided a single cane for her to use. R. 587.

On August 13, Douglas reported pain in her neck, back, and right shoulder and requested a Toradol shot. R. 603–04. She said the pain was brought on by heavy lifting and aggravated by exertion. On examination of Douglas's cervical and lumbar spine and right shoulder, Dr. Jalandhara noted all normal findings. He also noted that Douglas was a "poor historian with regards to pain. [E]verywhere I palpate, [she] says yes for tenderness/pain." He provided a Toradol injection. Two days later, Douglas reported to Dr. Alba that the Toradol had not eased her back pain, although it had helped in the past, and she requested "something stronger." R. 601–02. Dr. Alba noted decreased range of motion, pain upon extension and flexion, and paraspinous muscle spasm and tenderness over the lumbar spine.

On October 3, Douglas told Dr. Alba that Flexeril did not ease her muscle pain, but gabapentin was effective, although it interfered with her other medications. R. 629. She requested stronger pain medication, a shower chair, a referral to physical therapy, and an aide to help her clean at home. Dr. Alba noted that Douglas had muscle pain and spasm, but no gait or balance problems. Dr. Owusu-Yaw examined Douglas three days later. R. 633–35. Consistent with previous mental and physical examinations, he noted normal findings. His diagnosis was unchanged, and he continue to prescribe the same dose of Cymbalta.

## 2. *Medical Opinions*

DDS physician James Wickham, M.D., reviewed Douglas's medical records and determined that she had severe impairments of major joint dysfunction and hypertension. R. 94, 102. He assessed her physical RFC and determined that Douglas could lift twenty pounds

occasionally and ten pounds frequently; sit for six hours and stand or walk for six hours in an eight-hour workday; frequently climb stairs and ramps, stoop, and kneel; and occasionally crouch, crawl, and climb ladders, ropes, and scaffolds. R. 95, 105. On reconsideration, DDS physician Richard Surrusco, M.D., determined that Douglas did not have any severe impairments, and he did not provide a functional assessment. R. 113–15, 119–21.

3. *Douglas's Statements*

In forms submitted in support of her disability application, Douglas reported experiencing pain for the past twenty years throughout her body, but primarily in her back. R. 265–66. Her pain had increased in recent years from motor vehicle accidents and injuries. R. 275. Pain limited her activities of daily living, which consisted of doing light housework, preparing meals, taking care of her children, reading, and watching television. R. 268–72. She reported some limitations in self-care. R. 269. Someone usually accompanied Douglas and drove her to go to stores and to church. R. 271–72.

At the administrative hearing, Douglas testified that she experienced muscle weakness and pain. R. 47–48. Douglas said she felt depressed because she could not do things she once could. R. 50–51. Her medications made her sleepy, R. 54, and she could not sit, stand, or walk for long periods, R. 57–59. She could lift up to five pounds. R. 60. She explained that working as a pastor for a week did not require her to “do anything” and ministering to jail inmates took only ten minutes. R. 61–63.

B. *Analysis*

Douglas generally challenges the ALJ's finding that her mental and physical impairments do not preclude her from performing her past work. Pl.'s Br., ECF No. 14.

1. *Non-severe Mental Impairment*

At step two of his opinion, the ALJ determined that Douglas did not have a severe mental impairment. An “impairment is not severe if it does not significantly limit [the claimant’s] physical or mental ability to do basic work activities.” 20 C.F.R. §§ 404.1521(a), 416.921(a). With regard to a claimant’s mental functioning, “basic” work activities are things such as following simple instructions, responding appropriately to other people, and coping with changes in a routine work setting. *Id.* §§ 404.1521(b), 416.921(b). An impairment should be labeled “not severe only if it is a *slight abnormality* which has such a *minimal effect* on the individual that it would not be expected to interfere” with a claimant’s work activities. *Evans v. Heckler*, 734 F.2d 1012, 1014 (4th Cir. 1984) (internal quotation marks omitted); *see also Waller v. Colvin*, No. 6:12cv63, 2014 WL 1208048, at \*7 (W.D. Va. Mar. 24, 2014). This is not a difficult hurdle for the applicant to clear. *See Albright v. Comm’r of Soc. Sec.*, 174 F.3d 473, 474 n.1 (4th Cir. 1999); *Carr v. Comm’r of Soc. Sec.*, No. 4:10cv25, 2011 WL 1791647, at \*9 (W.D. Va. May 11, 2011). Still, this Court must affirm the ALJ’s severity finding if he applied the correct legal standard and if his conclusion is supported by substantial evidence in the record. *See Meyer*, 662 F.3d at 704.

ALJs use “a special technique” to evaluate the severity of an alleged mental impairment. 20 C.F.R. §§ 404.1520a(a), 416.920a(a). First, the ALJ evaluates the applicant’s symptoms and medical records to determine whether he has a “medically determinable mental impairment.” *Id.* §§ 404.1520a(b), 416.920a(b). If he does, the ALJ then rates the applicant’s resulting “degree of functional limitation” in four areas: activities of daily living; social functioning; concentration, persistence, or pace; and episodes of decompensation.<sup>2</sup> *Id.* §§ 404.1520a(c)(3), 416.920a(c)(3); *see also id.* pt. 404, subpt. P, app. 1 § 12.00(C). “Non-severe” mental impairments cause no more

---

<sup>2</sup> Limitations in the first three areas are measured on a five-point scale: none, mild, moderate, marked, or extreme. 20 C.F.R. §§ 404.1520a(c)(4), 416.920a(c)(4). Limitation in the fourth area is measured by the number of episodes of decompensation a person has experienced. *Id.*

than “mild limitations” in the first three areas and no episodes of decompensation. *Id.* §§ 404.1520a(d)(1), 416.920a(d)(1). As always, the ALJ must analyze all of the relevant evidence, articulate his rationale for crediting certain evidence, make required factual findings, and adequately explain the grounds for his conclusions at this stage. *See Bill Branch Coal Corp. v. Sparks*, 213 F.3d 186, 190 (4th Cir. 2000).

In discussing these four areas, the ALJ reviewed Douglas’s own functional report. He determined that Douglas had no limitation in activities of daily living and social functioning and mild limitation in maintaining concentration, persistence, or pace. He also found no episodes of decompensation. The ALJ’s reliance on Douglas’s functional report as his sole support for his findings in these areas is problematic, as her own statements suggest more than mild limitation. Any error in the ALJ’s analysis is, however, harmless. *See Bishop v. Comm’r of Soc. Sec.*, 583 F. App’x 65, 67 (4th Cir. 2014) (per curiam) (“[A]ny error is reviewed under the harmless error doctrine. Thus, if the decision ‘is overwhelmingly supported by the record though the agency’s original opinion failed to marshal that support, then remanding is a waste of time.’”) (quoting *Spiva v. Astrue*, 628 F.3d 346, 353 (7th Cir. 2010)); *see also Reid v. Comm’r of Soc. Sec.*, 769 F.3d 861, 865 (4th Cir. 2014) (explaining that the Fourth Circuit does not require procedural perfection, and finding that the claimant did not identify any “evidence not considered by the Commissioner that might have changed the outcome of his disability claim”).

The record amply supports the ALJ’s assessment that Douglas’s depression did not cause more than minimal functional limitation. R. 22. Douglas’s treating physicians consistently noted normal mental status exams throughout the relevant period. For example, on October 15, 2013, Dr. Owusu-Yaw conducted a mental exam showing normal signs with no evidence of concentration or memory problems or disorientation, despite Douglas’s claims of depression and

anxiety. R. 465, 467. He made the same findings at each visit through October 4, 2014. On December 5, 2013, Dr. Jalandhara examined Douglas and found that she had no recent or remote memory impairment and a normal attention span and ability to concentrate. R. 499–500. On April 2, 2014, Douglas reported to Ms. Andrews that she felt anxious and depressed, but by the end of the month, Ms. Andrews noted that Douglas was doing much better. R. 616, 619, 624, 625. Moreover, no acceptable medical source has diagnosed Douglas with depression, and she was not prescribed medications for depression. Additionally, neither DDS physician identified a severe mental impairment or any functional limitation associated with Douglas’s depression.<sup>3</sup> Accordingly, I find that substantial evidence supports the ALJ’s determination that Douglas’s depression was not a severe impairment.

## 2. *Residual Functional Capacity*

A claimant’s RFC is the most she can do on a regular and continuing basis despite her impairments. 20 C.F.R. §§ 404.1545(a), 416.945(a); SSR 96-8p, 1996 WL 374184, at \*1 (July 2, 1996). It is a factual finding “made by the Commissioner based on all the relevant evidence in the [claimant’s] record,” *Felton-Miller v. Astrue*, 459 F. App’x 226, 230–31 (4th Cir. 2011) (per curiam), and it must reflect the combined limiting effects of impairments that are supported by the medical evidence or the claimant’s credible complaints, *see Mascio v. Colvin*, 780 F.3d 632, 638–40 (4th Cir. 2015). The ALJ’s RFC assessment “must include a narrative discussion

---

<sup>3</sup> In discussing the evidence of Douglas’s depression at step two, the ALJ found that she had mild limitation in concentration, persistence, or pace, but he did not include such a restriction in the RFC. Failure to explain this discrepancy can constitute reversible error. *See Mascio v. Colvin*, 780 F.3d 632, 637–38 (4th Cir. 2015); *Ashcraft v. Colvin*, No. 3:13-CV-00417-RLV-DCK, 2015 WL 9304561, at \*9 (W.D.N.C. Dec. 21, 2015). Here, the ALJ noted examination findings and other reports that Douglas had normal mental exams and no concentration problems. R. 27, 31. Additionally, Douglas’s treating medical providers did not find any deficits in concentration, persistence, or pace. Indeed, Douglas did not claim to have concentration problems, although she did report that she often did not finish what she started. R. 273. Considering the entire record, I find overwhelming support for not including any limitations in the RFC attributable to Douglas’s depression.

describing” how specific medical facts and nonmedical evidence “support[] each conclusion” in his RFC finding, *id.* at 636, and explaining why he discounted any “obviously probative” conflicting evidence, *Arnold v. Sec’y of Health, Educ. & Welfare*, 567 F.2d 258, 259 (4th Cir. 1977); *see also Reid v. Comm’r of Soc. Sec.*, 769 F.3d 861, 865 (4th Cir. 2014). In discharging his duty to provide an assessment of a claimant’s “work-related abilities on a function by function basis,” the ALJ must make specific findings about the impact of a claimant’s impairments and credible, related symptoms on her ability to work. *Mascio*, 780 F.3d at 636; *accord Monroe v. Colvin*, -- F.3d --, 2016 WL 3349355, at \*9–10 (4th Cir. June 16, 2016).

The ALJ determined that Douglas had the RFC to perform light work consisting of lifting and carrying twenty pounds occasionally and ten pounds frequently; sitting for six hours and standing or walking for six hours in an eight-hour workday; never climbing ladders, ropes, or scaffolds; occasionally balancing and stooping; and avoiding concentrated exposure to hazards. R. 25. In reaching this assessment, the ALJ thoroughly and accurately reviewed the medical evidence, discussed the credibility of Douglas’s report of symptoms, and addressed the medical opinion evidence. R. 25–33.

The ALJ found not entirely credible Douglas’s report of symptoms and the limitations they caused. R. 31. When evaluating a claimant’s allegation that she is disabled by symptoms, such as pain, caused by a medically determinable impairment, the ALJ must first determine whether objective medical evidence shows that the claimant has a medically determinable impairment that could reasonably be expected to cause the kind and degree of pain alleged. 20 C.F.R. §§ 404.1529(a), 416.929(a); *see also Craig*, 76 F.3d at 594. If the claimant clears this threshold, then the ALJ must evaluate the intensity and persistence of the claimant’s pain to determine the extent to which it affects her physical or mental ability to work. SSR 96-7p, 1996

WL 374186, at \*2 (July 2, 1996); *see also Craig*, 76 F.3d at 595. The latter analysis often requires the ALJ to determine “the degree to which the [claimant’s] statements can be believed and accepted as true.” SSR 96-7p at \*2, \*4. The ALJ cannot reject the claimant’s subjective description of her pain “solely because the available objective medical evidence does not substantiate” that description. 20 C.F.R. §§ 404.1529(c)(2), 416.929(c)(2).

The ALJ determined that Douglas’s activities of daily living were not commensurate with her claimed limitations. Douglas reported to Ms. Andrews that she served as a pastor at her church for one week during the regular pastor’s absence, and she ministered to inmates at a jail. Although Douglas attempted to minimize these activities during her hearing testimony, the ALJ could reasonably question the extent of her claimed limitations in light of these activities.

The ALJ also noted that Douglas’s medications were effective in controlling her pain. R. 31. This observation is, however, not entirely accurate. At times Douglas did report pain relief from injections and medications, but she also regularly complained that she needed stronger medications to control her pain. Nonetheless, the ALJ found that this medication regimen and her other treatment was conservative, suggesting that her symptoms were not as limiting as she claimed. R. 32. This assessment is reasonable. Douglas’s physicians treated her with medications, injections, and referrals for short stints of physical therapy, and they encouraged her to exercise and lose weight. They did not recommend more significant treatment. While there is “no bright-line rule [for] what constitutes ‘conservative’ versus ‘radical’ treatment,” *Gill v. Astrue*, No. 3:11cv85, 2012 WL 3600308, at \*6 (E.D. Va. Aug. 21, 2012), “[a]n unexplained inconsistency between the claimant’s characterization . . . of [her] condition and the treatment [she] sought to alleviate that condition” can bear heavily on the claimant’s credibility, *Mickles v. Shalala*, 29 F.3d 918, 930 (4th Cir. 1994) (citing the current 20 C.F.R. § 416.929(c)(3)).

Additionally, the ALJ noted that imaging, clinical examinations and tests, and observations of functioning revealed limited abnormalities. R. 31–32. This assessment is accurate and lends substantial support to the ALJ’s analysis. Imaging of Douglas’s cervical and lumbar spine was unremarkable, and she had only minimal degenerative disc disease. From September 2013 through October 2014, Douglas’s treating physicians, Dr. Torres, Dr. Owusu-Yaw, and Dr. Jalandhara, conducted physical examinations, which revealed normal findings other than tenderness. The only abnormal finding Dr. Owusu-Yaw made was that Douglas could not heel or toe walk or perform tandem walking, but he also noted that she needed no assistance ambulating. Having thoroughly reviewed the record, the ALJ did not need to accept Douglas’s allegations of pain “to the extent they are inconsistent with the available evidence, including objective evidence of the underlying impairment, and the extent to which that impairment can reasonably be expected to cause the pain the claimant alleges she suffers.” *Craig*, 76 F.3d at 595.

On the whole, the ALJ’s credibility analysis withstands scrutiny. Considering Douglas’s activities, her conservative treatment, and the limited abnormalities shown in imaging and treatment notes, the ALJ could reasonably question Douglas’s claimed disabling symptoms.

The ALJ also discussed the DDS physicians’ opinions, which are the only medical opinions in the record. The ALJ must explain the weight given to all medical opinions, *Radford v. Colvin*, 734 F.3d 288, 295–96 (4th Cir. 2013), and his “decision ‘must be sufficiently specific to make clear to any subsequent reviewers the weight [he] gave’ to the opinion and ‘the reasons for that weight,’” *Harder v. Comm’r of Soc. Sec.*, No. 6:12cv69, 2014 WL 534020, at \*4 (W.D. Va. Feb. 10, 2014) (citing SSR 96–8p, at \*5). When weighing medical opinions, the ALJ must consider the following factors: the source’s medical specialty and familiarity with the claimant, the weight of the evidence supporting the opinion, and the opinion’s consistency with other

relevant evidence in the record. 20 C.F.R. §§ 404.1527(c), 404.1527(e)(2), 416.927(c), 416.927(e)(2).

The ALJ gave “greater weight” and “partial weight” to Dr. Wickham’s opinion and the limitations identified therein and “little weight” to Dr. Surrusco’s opinion that Douglas did not have a severe impairment. R. 33. The ALJ explained that Dr. Surrusco’s opinion was not consistent with the record. He adopted Dr. Wickham’s finding that Douglas could perform light work, but the ALJ added postural and environmental limitations to give Douglas the maximum benefit. While this explanation is somewhat deficient, *see Monroe*, 2016 WL 3349355, at \*11, the record contains no medical opinions offering greater limitations. Moreover, the consistently normal findings on physical exam provide additional support for the ALJ’s determination that Douglas can perform light work. *See Gordon*, 725 F.2d at 236 (an ALJ may rely upon a consulting physician’s opinion when it is consistent with the record). Douglas’s treating physicians consistently found that she had full or near-full strength in all extremities, full range of motion, and normal to minimally antalgic gait. Considering the lack of any credible contradictory evidence, the medical evidence showing mostly normal findings and Dr. Wickham’s opinion provide substantial evidence for the ALJ’s RFC determination.

### 3. *Past Relevant Work*

At step four, the ALJ addressed Douglas’s past relevant work. During the administrative hearing, the VE testified about Douglas’s past work. He testified that he had reviewed Douglas’s vocational information, and he classified her past work as follows: school personal tutor/attendant as medium, unskilled work; insurance agent and teacher’s aide as light, skilled work; and dispatcher and school admissions clerk as sedentary, semi-skilled work. R. 67, 69–71. This assessment corresponds with Douglas’s description of the physical demands of these jobs.

See R. 276–83. Having assessed Douglas’s RFC, the ALJ discussed the physical and mental demands of these jobs based on the information Douglas provided about them and the VE’s testimony, and the ALJ determined that she could perform her past relevant work as an insurance agent, teacher’s aide, dispatcher, and office clerk. R. 33–34. The ALJ correctly found that the demands of these jobs fell within Douglas’s RFC. Accordingly, the ALJ’s determination that Douglas could perform her past work is supported by substantial evidence.

#### 4. *New Evidence*

Finally, Douglas filed in this Court additional medical evidence that she did not submit to the Commissioner. ECF No. 9. Sentence six of 42 U.S.C. § 405(g) allows a court to remand for the consideration of additional evidence only if the evidence is new and material and good cause exists for its late submission. See 42 U.S.C. § 405(g). “Evidence is new within the meaning of this section if it is not duplicative or cumulative.” *Wilkins v. Sec’y, Dep’t of Health & Human Servs.*, 953 F.2d 93, 96 (4th Cir. 1991); see also *Borders v. Heckler*, 777 F.2d 954, 955 (4th Cir. 1985). “Evidence is material if there is a reasonable possibility that the new evidence would have changed the outcome.” *Wilkins*, 953 F.2d at 96. Douglas’s additional evidence consists of notes of phone messages between Douglas and her medical providers about medical complaints and administering prescriptions, ECF No. 9, at 16–39; ECF No. 9-1, at 1–19, and medical records documenting her continuing complaints of back and joint pain, ECF No. 9, at 2–15; ECF No. 9-1, at 20–28, and abdominal issues, ECF No. 9-1, at 29–45. These records are cumulative of other information in the record that was before the ALJ and the Appeals Council. Accordingly, I find that this evidence would not have warranted a different outcome had it been presented to the Commissioner.

#### IV. Conclusion

For the foregoing reasons, I respectfully recommend that the Commissioner's motion for summary judgment, ECF No. 15, be **GRANTED**, the Commissioner's final decision be **AFFIRMED**, and this case be **DISMISSED** from the Court's active docket.

**Notice to Parties**

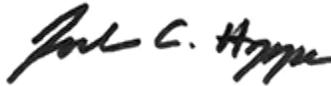
Notice is hereby given to the parties of the provisions of 28 U.S.C. § 636(b)(1)(C):

Within fourteen days after being served with a copy [of this Report and Recommendation], any party may serve and file written objections to such proposed findings and recommendations as provided by rules of court. A judge of the court shall make a de novo determination of those portions of the report or specified proposed findings or recommendations to which objection is made. A judge of the court may accept, reject, or modify, in whole or in part, the findings or recommendations made by the magistrate judge. The judge may also receive further evidence or recommit the matter to the magistrate judge with instructions.

Failure to file timely written objections to these proposed findings and recommendations within 14 days could waive appellate review. At the conclusion of the 14 day period, the Clerk is directed to transmit the record in this matter to the Honorable Jackson L. Kiser, Senior United States District Judge.

The Clerk shall send certified copies of this Report and Recommendation to the parties.

ENTER: August 22, 2016



Joel C. Hoppe  
United States Magistrate Judge