

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

MICHAEL NEWMAN,)	
Plaintiff,)	
)	Civil Action No. 4:15-cv-11
v.)	
)	<u>REPORT AND RECOMMENDATION</u>
CAROLYN W. COLVIN,)	
Commissioner of Social Security,)	By: Joel C. Hoppe
Defendant.)	United States Magistrate Judge

Plaintiff Michael Newman asks this Court to review the Commissioner of Social Security’s (“Commissioner”) final decision denying his applications for disability insurance benefits (“DIB”) and supplemental security income (“SSI”) under Titles II and XVI of the Social Security 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. 12. Having considered the administrative record, the parties’ briefs, and the applicable law, I find that substantial evidence supports the Commissioner’s decision that Newman was not disabled during the period at issue in this appeal. Therefore, I recommend that the Court **DENY** Newman’s Motion for Summary Judgment, ECF No. 13, **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* 20 C.F.R.

§§ 404.1520(a)(4), 416.920(a)(4); *Heckler v. Campbell*, 461 U.S. 458, 460–62 (1983). 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

Newman applied for DIB and SSI on January 26, 2012, and January 31, 2012, respectively. Administrative Record (“R.”) 255–65, ECF No. 8. He alleged disability caused by atrial fibrillation, type II diabetes, degenerative disc disease, high blood pressure, sleep apnea, asthma, and chronic obstructive pulmonary disease (“COPD”), beginning on January 10, 2006. At the date of his alleged onset, Newman was forty-six years old and had worked as a restaurant manager. R. 279–88. This was Newman’s third application for benefits. His first claim was denied by an ALJ on December 4, 2009, R. 70–81, and the Appeals Council declined his request for review on August 26, 2010, R. 86–88. A different ALJ denied Newman’s second claim on April 29, 2011, R. 92–103, and the Appeals Council declined review of that decision on November 30, 2011, R. 110–12.

Disability Determination Services (“DDS”), the state agency, denied Newman’s third claim at the initial and reconsideration stages. R. 116–37, 140–65. On November 7, 2013, he appeared with counsel at an administrative hearing before ALJ Brian B. Rippel. R. 36–66. The ALJ heard testimony from Newman, R. 40–53, and a vocational expert (“VE”), R. 53–64. Following the hearing, Newman, through counsel, amended his alleged onset date to December 31, 2011, his date last insured for DIB. R. 278.

ALJ Rippel issued a partially favorable decision on December 13, 2013. R. 17–30. He found that Newman had severe impairments of atrial fibrillation, cirrhosis, hypertension, asthma/COPD, a shoulder impairment, diabetes mellitus, obstructive sleep apnea, and alcohol

abuse. R. 20. The ALJ next determined that none of Newman’s impairments, alone or in combination, met or medically equaled the severity of an impairment listed in 20 C.F.R. Part 404, Subpart P, Appendix 1—in particular Listings 1.02 (major dysfunction of a joint), 3.02 (chronic pulmonary insufficiency), 3.03 (asthma), 4.02 (chronic heart failure), 4.04 (ischemic heart disease), 4.05 (recurrent arrhythmias), and 5.05 (chronic liver disease). R. 20–21.

ALJ Rippel then found that prior to November 1, 2012, Newman had the residual functional capacity (“RFC”)¹ to perform light work² with some postural and environmental limitations. R. 21–26. With this RFC, Newman could not perform his past relevant work, but could perform other jobs existing in the national and regional economies, including hand packager and inspector. R. 28–29. Newman was therefore found not to be disabled prior to November 1, 2012. R. 29.

The ALJ also found, however, that beginning on November 1, 2012, Newman had the RFC to perform only sedentary work³ with postural and environmental limitations. R. 26–28. This more limited RFC made Newman unable to perform any jobs existing in the national and regional economies. R. 28–29. Newman was therefore found to be under a disability from November 1, 2012, through the date of the ALJ’s decision and was entitled to receive SSI for this period. R. 29–30. He could not receive DIB, however, because the period of disability began

¹ A claimant’s RFC is the most he or she can do on a regular and continuing basis despite his or her impairments. 20 C.F.R. §§ 404.1545(a), 416.945(a); SSR 96-8p, 1996 WL 374184, at *1 (July 2, 1996).

² “Light” work involves lifting no more than twenty pounds at a time, but frequently lifting objects weighing ten pounds. 20 C.F.R. §§ 404.1567(b), 416.967(b). A person who can meet these lifting requirements can perform light work only if he also can “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).

³ “Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying [objects] like docket files, ledgers, and small tools.” 20 C.F.R. §§ 404.1567(a), 416.967(a). A person who can meet those lifting requirements can perform a full range of sedentary work if he or she can sit for about six hours and stand and walk for about two hours in a normal eight-hour workday. *See Hancock v. Barnhart*, 206 F. Supp. 2d 757, 768 (W.D. Va. 2002); SSR 96-9p, 1996 WL 374185, at *3 (July 2, 1996).

after his date last insured. *Id.* The Appeals Council declined Newman’s request for review, R. 1–3, and this appeal followed.

III. Facts

A. *Newman’s Prior Claims*

1. *July 2007 through December 2009*

The record reflects Newman’s treatment history for a variety of ailments dating back to July 2007. Around that time, Newman, who had undergone a posterior cervical decompression in the past, complained of pain in his neck and right shoulder, along with numbness and dyesthesias in his right arm and hand. R. 678, 1663. Gregory Helm, M.D., with the Neurosurgery Clinic at the University of Virginia Health System (“UVAHS”), indicated that these symptoms were caused by degenerative changes in Newman’s cervical spine. R. 1663; *see also* R. 1770–71 (MRI of the cervical spine). On September 27, 2007, Newman underwent a C5-C6 and C6-C7 anterior discectomy and fusion, R. 1655–58, which provided some relief from his symptoms, R. 680–84. Newman’s neck pain later returned, along with pain in his left shoulder and arm, R. 1641, and on April 29, 2008, he underwent a left-sided C6-C7 partial hemilaminectomy and excision of a bone spur, R. 1639–40. This procedure seemed to relieve Newman’s neck pain. *See* R. 1633–36. His shoulder pain continued, however, *id.*, and an MRI showed degenerative changes of the AC joint and mild subacromial bursitis, R. 1784.

In addition to the issues with his shoulder and cervical spine, Newman also complained of pain in his lower back. R. 1654. An MRI of Newman’s lumbar back, taken on November 17, 2007, revealed mild kyphosis, caused by chronic T12 end plate compression deformity; mild level lumbar degenerative changes; and mild left foraminal stenosis at L3-L4 and L4-L5 resulting from disc protrusion. R. 1776–77. There was no evidence of nerve root compression. R.

1643. Newman also experienced some occasional digestive issues. He reported rectal bleeding and constipation, R. 678–79, and black or bloody stools with abdominal pain and dyspepsia, R. 1651–53, 1661. Newman’s abdominal pain resolved after he stopped taking nonsteroidal anti-inflammatory drugs (“NSAIDs”) on a daily basis, and he was advised to take antacids as needed. R. 1647–48. A colonoscopy performed on December 7, 2007, revealed inflammatory polyps, which were removed, and small internal hemorrhoids. R. 1649–50.

The record also includes early findings regarding Newman’s heart and lung conditions. He complained of chest pain that originated in his back accompanied by shortness of breath, and he exhibited wheezing on physical examination, but an EKG demonstrated normal sinus rhythm with no other abnormalities. R. 1660–61. A stress test echocardiogram performed on March 5, 2009, was negative for evidence of myocardial ischemia, showed a normal heart rate and response and exaggerated blood pressure response, and exhibited rare premature ventricular contraction. R. 1793–95. On August 28, 2009, Newman underwent a sleep study and was diagnosed with moderate to severe sleep apnea, with his lowest oxygen level at 88%. R. 1625–30. He was given a prescription for a CPAP machine. Newman initially experienced some relief from his sleep apnea symptoms, but later had to discontinue using his CPAP because of a cough. R. 1623.

On September 26, 2009, Newman checked into Halifax Regional Hospital with complaints of palpitations and was diagnosed with atrial fibrillation with rapid ventricular response. R. 585–90.⁴ A CT pulmonary angiogram and chest X-ray were normal. R. 614–15. A persantine/cardiolute stress test revealed no ischemic ST-T wave changes, but did show wall

⁴ Newman also complained of nausea and vomiting at the time he reported to the hospital, but these symptoms cleared up on their own and appear to have been caused by a viral syndrome. *Id.* In addition, he reported elevated blood sugar levels with pain in his legs and blurred vision. He was prescribed Amaryl and advised to monitor his blood sugars at home daily, improve his diet and exercise, and decrease his alcohol intake. R. 591–92.

motion abnormality with reduced ejection fraction to 47%. R. 616. An echocardiogram, however, showed no wall motion abnormalities and a preserved ejection fraction of around 55%. R. 617.

ALJ Charles Boyer issued an opinion on December 4, 2009, denying Newman's first claim for disability benefits. R. 70–81. He found that Newman had severe impairments of disorders of the lumbar and cervical spine, cervical radiculopathy, degenerative joint disease of the left shoulder, diabetes mellitus, and atrial fibrillation, but also found that Newman did not have any severe respiratory or mental health impairment. R. 72–76. The ALJ determined that Newman's impairments did not meet a listing, R. 76–77, and found that he had the RFC to perform light work with additional limitations in crawling, reaching overhead, and climbing ladders, ropes, or scaffolds, R. 77–79. ALJ Boyer observed that Newman's complaints of severe pain were not supported by the record, noting that Newman did not require regular use of prescribed pain analgesics, but instead took over the counter medication. R. 78. He also found that Newman was noncompliant with his doctors' recommendations, including that he attend physical therapy and quit drinking and smoking. *Id.* In addition, the ALJ noted that objective medical findings were minimal except regarding the condition in Newman's cervical spine. *Id.*

2. *December 2009 through April 2011*

Following ALJ Boyer's unfavorable decision, Newman continued to complain of issues with his heart and lungs. Newman reported to the emergency room at Halifax Regional Hospital on May 23, 2010, stating that his occasional palpitations had escalated to a persistent episode of heart fluttering and that he experienced shortness of breath and pain that radiated from his chest to his jaw. An EKG showed atrial fibrillation with rapid ventricular response. On physical examination, Newman's lungs were clear, but his heart demonstrated irregular rhythm. He was

noncompliant with his CPAP regimen. R. 411–16. By November 2010, Newman reported that he had not experienced chest pain, palpitations, or shortness of breath since being hospitalized. R. 475. In February 2011, Newman visited the Halifax Heart Center complaining of chest pain, dyspnea on exertion, orthopnea, paroxysmal nocturnal dyspnea, palpitations, lightheadedness, and easy fatigue. Myocardial perfusion imaging and an echocardiogram revealed normal findings, including ejection fraction of 60–66%. R. 338–42, 344. In July 2011, Newman reported again that he had not experienced any recent chest pain or palpitations. R. 465–67.

Newman also continued to complain about musculoskeletal pain at this time. In November 2010, Newman informed his primary care physician, John Schorling, MD, that he continued to experience severe neck pain, but also noted that the pain was now localized to his neck and did not radiate. He treated this pain with acetaminophen, which provided some relief, and was referred to the pain clinic at UVAHS. R. 475–77. On January 24, 2011, Newman reported experiencing a constant ache, made worse by palpation, that was located between his shoulder blades and centered over his spine. Newman also stated that he had some residual pain in his neck, paresthesia in both hands, and left rotator cuff problems. He claimed mild pain relief from Topamax, Celexa, and ibuprofen. R. 472–74. On February 8, he reported to the UVA Sports Medicine Clinic for assessment of his shoulder pain. Clinical findings were consistent with an impingement syndrome or potentially low-grade partial thickness rotator cuff injury, and Newman received a corticosteroid injection. R. 470–71; *see also* 485 (X-ray of left shoulder). By April 2011, Newman’s shoulder symptoms had not improved, but he was advised to continue with his home exercise program. R. 469–70; *see also* 483 (MRI of left shoulder).

The record from this period also contains some limited information regarding Newman’s other miscellaneous ailments. In May 2010, when he was hospitalized for atrial fibrillation,

Newman reported that he recently had issues with his diabetes, which appeared uncontrolled, with blood glucose greater than 300, on mild therapy with Metformin. Lab work was positive for blood alcohol level of 0.167, which doctors opined may have triggered Newman's uncontrolled atrial fibrillation. R. 411–16. He reported in November 2010 that he had run out of test strips and was therefore unsure of his blood glucose level, but he did not endorse any symptoms related to his diabetes. Newman had dramatically cut down on his drinking at this time, going from six beers per day to less than six beers per week, and stated that he would like to stop completely. He was prescribed Topamax for help with quitting alcohol and Celexa for depression. R. 475–77.

ALJ Brian Kilbane issued an opinion on April 29, 2011, denying Newman's second claim for benefits. R. 92–103. He found that Newman had severe impairments of degenerative disk disease, diabetes mellitus, ischemic heart disease, and asthma, but also found that Newman's medically determinable impairment of an affective disorder was nonsevere. R. 94–95. The ALJ determined that Newman's impairments did not meet a listing, R. 95–96, and found that he had the RFC to perform light work with additional environmental limitations and limitations on climbing ramps and stairs; stooping; crouching; crawling; climbing ladders, ropes, or scaffolding; and reaching overhead, R. 96–101. ALJ Kilbane observed that Newman's claims of severe pain caused by his back condition were not supported by the record, noting that his treatment had been routine and conservative and that his primary complaint had actually been related to the separate impairment in his shoulder. Furthermore, imaging showed only mild degenerative changes in Newman's shoulder, and he had not followed up with the pain clinic after being referred there. With regard to Newman's heart condition, the ALJ noted that treatment findings by his cardiologist were normal and that Newman's worst incident of uncontrolled atrial fibrillation—his May 2010 hospitalization—was potentially triggered by his

high blood alcohol level. Finally, with regard to Newman's diabetes, the ALJ observed that Newman had been noncompliant in his treatment because he did not monitor his glucose level at home, alter his diet, or reduce his alcohol consumption. R. 100–01.

B. Newman's Current Claim

1. The Relevant Period: December 2011 through October 2012

The first record evidence following Newman's alleged onset date of December 31, 2011,⁵ is of a visit with Dr. Schorling on January 31, 2012, for management of several of Newman's medical problems. Newman reported to Dr. Schorling that his glucose level was recently elevated at between 200 and 300 and that he had lost about five to ten pounds. Newman complained of polyuria and polydipsia, stating that he urinated a large amount up to twenty times per day. He stated that he continued to drink up to six beers per day and a pint of whiskey per week. He had not been checking his blood pressure at home, but he also had not recently experienced chest pain, shortness of breath, or palpitations. He continued to take Warfarin managed by his local cardiologist. Newman's review of symptoms was positive for fatigue, unexpected weight change, diarrhea, urgency and frequency of urination, back pain and arthralgias, and dysphoric mood. His physical examination was fully normal except for glucose of 233. Dr. Schorling increased Newman's metformin dosage, started him on glipizide, and advised him to track his glucose at home. He also adjusted Newman's medications for hyperlipidemia and prescribed Cymbalta for his depression, with the hope that it would also help with his chronic pain. R. 460–63.

⁵ The only treatment record of note between ALJ Kilbane's decision in April 2011 and the alleged onset date is of a July 5, 2011, visit with Dr. Schorling. Newman reported that he had resumed drinking more heavily, but claimed that he still wished to quit. Clinical findings were unremarkable, and Newman was assessed with alcohol dependence, hypertension, poorly controlled diabetes, and depression, which was stable. R. 465–67.

On March 14, Donna White, R.Ph., at UVAHS, evaluated Newman's diabetes. Newman reported that his blood glucose had gone down into the 70s after adjusting his medications and that he subsequently decreased his metformin dosage. He complained of paresthesia of the feet, polydipsia, polyuria, and visual disturbances. Newman also stated that he drank seven ounces of whiskey per day, and reported diarrhea, white stools, and abdominal pain resulting from his alcohol use. In addition, he had recently run out of medication for his asthma. He denied chest pain, but reported shortness of breath and some lightheadedness. He was instructed to increase his dosage of metformin again and to try to manage his diabetes through diet and exercise. R. 456–59.

On June 12, Newman reported to Halifax Heart Center with complaints of sharp chest pain made worse by activity and lasting for a period of hours or all day. He also reported experiencing dyspnea on exertion, orthopnea, paroxysmal nocturnal dyspnea, palpitations occurring three to four times per month, lightheadedness, easy fatigue, and hip and back pain. His chart notes that he was noncompliant with his CPAP. R. 548. Myocardial perfusion testing conducted on June 21 was normal, with left ventricle ejection fraction at 61%. R. 556. An echocardiogram conducted the same day also showed normal overall ventricular systolic function, with an ejection fraction between 55 and 60%, normal diastolic filling pattern, no evidence of pulmonary hypertension, and no pericardial effusion, but also showed trace mitral regurgitation and trace tricuspid regurgitation. R. 554–55.

Newman returned to Dr. Schorling on June 28. He stated that his glucose levels were still elevated to between 200 and 300 and that he was still drinking heavily. He denied chest pain, shortness of breath, or palpitations. His physical examination was normal except for tenderness over the left anterior shin and elevated hemoglobin A1c. Newman told Dr. Schorling that he did

not think he could reduce his alcohol or tobacco use at that time. R. 631–33. Newman reported to Halifax Heart Center on July 2, complaining of chest pain, dyspnea on exertion, orthopnea, tachycardia, lightheadedness, and easy fatigue. Physical examination revealed an irregular heart rate and rhythm, but was otherwise normal. R. 547. Subsequent cardiac event monitoring indicated atrial fibrillation with rapid ventricular response. R. 549–50.

Newman returned to Halifax Heart Center on August 2, complaining of chest pain occurring two to four times per week and lasting a few hours, dyspnea on exertion, tachycardia, lightheadedness, dizziness, near syncope, and easy fatigue. His physical exam was normal, and his medications were adjusted. R. 546. An X-ray revealed no acute cardiopulmonary findings and slight ventral wedging of L1. R. 559. On follow-up with his cardiologist one week later, Newman endorsed some improvement in his palpitations and an increase in lightheadedness. He was advised to reduce his smoking and drinking and return in four weeks. R. 545. He returned to Halifax Heart Center on September 13. He reported no chest pain and stated that his palpitations continued to improve. Physical examination was normal other than irregular heart rate and rhythm and elevated blood pressure of 154/86. Newman stated that he had run out of medication and was switched to Cardizem. R. 569.

On September 25, 2012, Newman reported to Dr. Schorling with complaints of abdominal pain, nausea, vomiting, and rectal bleeding over the previous month. He also complained of occasional lightheadedness when getting up quickly, but no syncope. Newman stated that he had decreased his alcohol intake and was encouraged to abstain. Review of systems was positive for fatigue, cough, shortness of breath, hematochezia, back pain and arthralgias, and dysphoric mood. Physical examination was normal except for abdominal distension, abdominal tenderness, and enlarged prostate. Dr. Schorling opined that Newman's symptoms were

consistent with gastritis and hemorrhoids. R. 698–701. On follow-up two days later, Newman stated that he had not experienced any further rectal bleeding or vomiting, but continued to have some nausea. His hemoglobin A1c was elevated at 9.1, and Dr. Schorling discussed starting insulin treatment, but Newman stated that he wanted to try to quit drinking first and see if that would help control his glucose. R. 710.

Newman returned to the cardiologist for a follow-up on October 25. He reported less nausea and fewer episodes of palpitations, but also complained that rectal bleeding had resumed multiple times daily. Physical examination was normal except for irregular heart rhythm. He was diagnosed with chronic, controlled atrial fibrillation; fatigue caused by anemia or low blood pressure; acute, moderate rectal bleeding; and chronic, controlled shortness of breath. Newman was advised to continue his medication, quit smoking, reduce his alcohol consumption, and improve his diet and exercise. R. 1515–17.

2. Onset of Disability: November 2012 through Present

After November 1, 2012 (the disability onset date as determined by the ALJ), the record indicates that Newman experienced increasingly severe symptoms caused by a variety of impairments. On November 5, he reported to Michael Devitt, M.D., at UVAHS, with complaints of nausea, vomiting, diarrhea, blood in the stool, and abdominal pain, which he said he had experienced for the previous six weeks. He described having twenty to fifty bowel movements per day and described his intermittent abdominal pain as “sharp and stabbing” and radiating to his shoulder blades. Newman stated that his symptoms improved when he ate smaller meals of softer foods and that he could drink water and alcohol, but had quit drinking alcohol four days earlier. On physical examination, his abdomen was mildly distended and diffusely tender to palpation. R. 731–33.

Newman underwent a colonoscopy and upper GI endoscopy on November 14. The colonoscopy revealed several small polyps, which were removed, and moderate internal hemorrhoids. The endoscopy revealed Grade II esophageal varices,⁶ which were banded and completely depressed, and a gastric mucosal abnormality in the stomach characterized by erythema. R. 753–56. By December 20, Newman’s gastrointestinal symptoms had continued, but were somewhat less severe. He was still attempting to quit drinking for good (he reported having his last drink four days earlier) and experienced some anxiety, tremor, and difficulty sleeping, but no hallucinations. He was prescribed Topamax to help reduce withdrawal and was diagnosed with esophageal varices, dyslipidemia, bacterial overgrowth syndrome, and cirrhosis. R. 860–62.

One week later, Newman complained of weakness in his legs, greater on the right than the left, and reported having fallen twice. Newman claimed that he felt more unstable since he stopped drinking. On examination, Newman displayed decreased sensation in his feet and difficulty walking on his toes, and he fell while heel-to-toe walking. He was tender to palpation over his lower thoracic and lumbar spine and paraspinal muscles. Newman was referred for an MRI to determine whether his lower back condition contributed to his lower extremity weakness. R. 891–94. The MRI, taken on January 8, 2013, showed left paracentral/foraminal disc osteophytic protrusion in conjunction with facet arthropathy at L4-L5, resulting in abutment of the exiting left L4 nerve root within the neural foramen as well as moderate left neuroforaminal stenosis. The examining physician determined that this imaging was grossly unchanged from the imaging of Newman’s lumbar spine taken in November 2007. R. 1063–65. In February 2013, Dr. Schorling opined that Newman’s lumbar MRI was stable and thought that his gait disturbance could be attributable to a cerebellar problem caused by alcohol, low blood pressure, or side effects of medications. R. 1159–61.

⁶ Newman’s esophageal varices confirmed a diagnosis of cirrhosis related to alcohol abuse. R. 1585.

Newman's symptoms continued to worsen, and on March 11 he reported that his leg weakness and balance problems continued. Additionally, he reported having difficulty with swallowing and word finding. Newman also complained of burning sensations in his hands, forearms, feet, and legs. He stated that he was often tired during the day, but also noted that he was not wearing his CPAP mask. He was diagnosed with dysmetria and dysdiadochokinesia, likely secondary to chronic alcohol use; dysphagia, with no apparent mechanical obstructions; sleep apnea; and neuropathy, likely secondary to chronic alcohol use and diabetes. He was ordered to undergo a brain MRI and instructed to obtain a more comfortable CPAP mask. R. 1212–15. Two days later, Newman reported to the emergency room with complaints of weakness, dizziness, and near syncope. Around the time these symptoms occurred, Newman recorded a low blood pressure of 87/55, possibly secondary to starting on nadolol. A head CT scan revealed partial opacity of the inferior maxillary sinuses bilaterally with no acute intracranial process. Against doctors' advice, Newman opted not to stay in the hospital overnight. R. 1343–45.

Newman continued to complain of loss of coordination and dizziness over the next few months, along with occasional staring spells, drooling, and difficulty swallowing, and he continued to abstain from alcohol. R. 1523–28, 1582–95. The record is not clear as to the exact diagnosis for these symptoms—doctors have opined that they may result from hepatic encephalopathy, R. 1582, 1593; chronic ataxia from a history of alcoholism, R. 1593; or reduced metabolism of Cymbalta caused by cirrhosis, R. 1588. A brain MRI taken on April 11 showed some mild changes of chronic small vessel ischemic disease, but no other significant abnormalities. R. 1789. He also continued to demonstrate mild cardiopulmonary impairments. He complained of some chest pain, palpitations, and shortness of breath. *See generally* R. 1523–

50. Objective findings showed mild defects. A July 2 echocardiogram revealed mild impairment of overall left ventricular systolic function, with an ejection fraction between 45 and 50%. R. 1334–35. Myocardial perfusion imaging performed three days later showed normal wall motion and an ejection fraction of 61%, but also showed a fixed defect in the septal wall that was small in size and moderate in intensity. R. 1333.

During this period, Newman also made occasional claims of musculoskeletal pain. On August 13, Newman told Dr. Schorling that the chronic back pain associated with his T12 compression fracture had been getting worse over the past several weeks. He stated that the pain was localized to his mid-back and made worse with movement. On physical examination, he exhibited tenderness and swelling, but no deformity or spasm. Dr. Schorling prescribed a trial course of cyclobenzaprine and oxycodone. R. 1179–81. On August 25, Newman reported to the emergency department at Halifax Regional Hospital complaining of increased back pain after being thrown from a lawn mower. Pain was located in the thoracic and lumbosacral regions and made worse with movement. He exhibited bony tenderness over T10-12 and mild kyphotic changes of the spine, but also had adequate range of motion, no paravertebral spasm, and no definite trigger point. Newman ambulated without assistance, but with some difficulty and used a cane. R. 1313–16. X-rays and a CT scan showed no acute fracture, but did show chronic-appearing changes of the T11-12 interspace with widening of the interspinous distance and associated focal mild dorsal kyphosis, as well as anterior wedging at T12 associated with osteophyte formation between T12 and L1. There were other degenerative changes scattered throughout the thoracic and lumbar spine, but these appeared to be mild. R. 1324–28.

On October 2, Newman reported improvement in his back pain with the regimen of cyclobenzaprine and oxycodone. He complained of difficulties with his left shoulder and

exhibited limited range of motion. R. 1182–84. Newman continued to complain of shoulder pain one week later, stating that it had worsened after he flipped his lawnmower in August and that it was exacerbated by overhead work and heavy lifting. He also complained of associated neck pain, numbness, and tingling. X-rays demonstrated AC joint degenerative changes. Newman was assessed with mild tendinopathy along with moderate arthritis and was referred for corticosteroid injection. R. 1563–66.

3. *Newman's Submissions and Testimony*

Newman submitted reports to DDS on February 20, 2012, in which he described his pain and his functional abilities. Regarding his pain, Newman stated that he received no benefit from pain medication and that the pain had limited his functioning for the past ten years. He described constant pain in his neck, shoulders, and middle to lower back, along with occasional pain in his hips, knees, ankles, and feet. He also claimed to experience pain from his atrial fibrillation that radiated from his chest to his throat and jaw. Newman stated that his pain was made worse by physical activity to the point where he would get nauseous and vomit if he pushed himself too hard. R. 290–91.

Regarding his activities of daily living, Newman stated that on a typical day he would eat, take his medication, tidy up, and then nap on the couch. R. 293. He claimed that his impairments prevented him from doing activities that he used to do, such as cutting the grass, golfing, bowling, working on his car, and performing housework. Newman reported that he had trouble sleeping because of his chronic pain and his sleep apnea. He stated that he had difficulty dressing because he could not button shirts or use his fingers or hands, and he also claimed to have difficulty bathing because he could not bend over or raise his hands over his head. R. 294. He still prepared his own meals every day, although he said that this took longer than it used to

take. R. 295. He also stated that he could occasionally help with the dishes, shop for groceries, and handle his finances (although he claimed to have difficulty with physically handling cash because of problems with his fingers). R. 295–97.

Newman claimed that he sometimes went outside depending on the weather, but also stated that he did not go out to socialize. R. 296–98. He reported that side effects from his medication made him forgetful and distracted, impaired his ability to drive, and caused anxiety in social settings. R. 295–96, 298–99. As to his functional abilities, Newman claimed that he could not lift more than ten pounds or walk more than one hundred feet without rest. R. 298. He stated that he had trouble with squatting, bending, standing, reaching, walking, sitting, kneeling, stair climbing, and using his hands ever since his first back surgery twelve years earlier. R. 300. He complained of difficulty with concentrating and handling stress. R. 298–99. He also stated that he used lift belts and a back brace for assistance. R. 299.

In his testimony before ALJ Rippel, Newman stated that he had used a cane to ambulate for the past four years and that he used it every day for the past two years. R. 42–43. He testified that his atrial fibrillation made him extremely fatigued and was triggered by stress, pain, and lack of sleep. R. 45–46. Newman stated that he suffered asthma attacks three to four times per month and lost his breath easily because of his COPD. R. 46–47. He testified that he used a nebulizer for a couple hours every day to treat his pulmonary conditions and that it took him thirty to forty-five minutes to take all of his other medications. R. 47, 49–50. He claimed to have difficulty using his CPAP machine and stated that he woke up frequently in the night because of his sleep apnea and pain. R. 47.

Newman testified that he was still unable to cut back on smoking cigarettes, but also stated that he had successfully quit drinking after learning of his cirrhosis, having relapsed only

one time. R. 47–49. He claimed that he had difficulty walking a full city block because of his shortness of breath, dizziness, and coordination difficulties. He testified that he could stand for only fifteen to twenty minutes and could not perform chores around the house. R. 50–51. He also claimed that he suffered from bouts of depression, but he agreed that this condition was somewhat improved with medication and that he did not see a mental health specialist. R. 51. He told the ALJ that he reported to the hospital in March 2013 in a state of confusion, but he was not certain whether this incident was caused by alcoholic encephalopathy or by some other condition. R. 52–53.

4. ALJ Rippel's Decision

ALJ Rippel found that Newman's atrial fibrillation, cirrhosis, hypertension, asthma/COPD, shoulder injury, diabetes, sleep apnea, and alcohol abuse were severe impairments. He also determined that Newman's depression was nonsevere because Newman did not see a specialist, had experienced improvement with medication, had an essentially normal mood and affect, and could understand and remember simple instructions, communicate with others, and act in his own best interests. Furthermore, the ALJ noted that Newman's activities of daily living were not significantly limited by depression. R. 20. Notably, the ALJ did not address whether Newman's degenerative back condition was a severe impairment.

The ALJ found that Newman's impairments prior to November 1, 2012, restricted him to light work with additional environmental limitations and limitations on climbing, balancing, stooping, kneeling, crouching, crawling, and reaching overhead. R. 21–26. He found that Newman's medically determinable impairments could reasonably be expected to cause his alleged symptoms, but determined that Newman's statements concerning the intensity, persistence, and limiting effects of his symptoms during this period were not entirely credible.

He noted that examination findings prior to November 1, 2012, were essentially normal and that Newman's course of treatment was generally routine and conservative, with no visits to any specialists other than his cardiologist and a nutritionist. Newman's diabetes, heart issues, and lung condition did not require frequent hospitalization or surgical treatment, and his symptoms were well controlled with medications. The ALJ also observed that Newman was occasionally noncompliant with treatment recommendations, as he did not use his CPAP machine, test his blood pressure and glucose levels at home, or quit using alcohol and tobacco. R. 24–25. ALJ Rippel gave considerable weight to ALJ Kilbane's April 2011 decision because the evidence of record during the relevant period did not document significant changes in Newman's overall condition since that decision. He gave less weight to the opinions of the DDS medical consultants, who opined that Newman could perform light work with fewer postural limitations. Instead, ALJ Rippel chose to adopt substantially the RFC set out in ALJ Kilbane's decision. R. 25–26.

For the period beginning on November 1, 2012, ALJ Rippel determined that Newman could only perform sedentary work (with additional postural and environmental limitations). He recited the relevant record, but otherwise gave little reasoning for finding that Newman's RFC had diminished. The ALJ stated that Newman's allegations regarding his symptoms and limitations were generally consistent with the medical record during this period. He also determined that after this date, the opinions of ALJ Kilbane and the DDS consultants were no longer consistent with the medical evidence of record. R. 26–28.

IV. Discussion

Newman argues that the ALJ erred in determining that he was not disabled from his alleged onset date of December 31, 2011, until November 1, 2012. He first argues that the RFC

determination for this period was deficient because the ALJ failed to conduct a function-by-function assessment. Pl. Br. 4–5, ECF No. 14. In assessing a claimant’s RFC, the ALJ “must first identify the individual’s functional limitations or restrictions and assess his or her work-related abilities on a function-by-function basis” before the RFC may be stated “in terms of the exertional levels of work, sedentary, light, medium, heavy, and very heavy.” *Mascio v. Colvin*, 780 F.3d 632, 636 (4th Cir. 2015) (quoting SSR 96-8p, 1996 WL 374184, at *1 (July 2, 1996)). The ALJ’s RFC assessment “must include a narrative discussion describing” how specific medical facts and nonmedical evidence “support[] each conclusion” in his RFC finding. *Id.* (quoting SSR 96-8p, 1996 WL 374184, at *7). Here, Newman asserts that the ALJ failed to explain how the evidence of record supported each part of his RFC finding, including Newman’s ability to sit, stand, walk, lift, carry, push, and pull, and he claims that this constituted reversible error. Pl. Br. 4–5.

This argument fails for a number of reasons. First, *Mascio* does not set out “a per se rule requiring remand when the ALJ does not perform an explicit function-by-function analysis.” 780 F.3d at 636. Instead, remand should be considered “where an ALJ fails to assess a claimant’s capacity to perform relevant functions, despite contradictory evidence in the record, or where other inadequacies in the ALJ’s analysis frustrate meaningful review.” *Id.* (quoting *Cichocki v. Astrue*, 729 F.3d 172, 177 (2d Cir. 2013)). Thus, Newman cannot claim error simply because the ALJ did not explicitly set forth a detailed analysis for each of Newman’s functional abilities as long as the ALJ’s conclusions are ascertainable from his narrative discussion and supported by the record.

ALJ Rippel provided adequate support for his RFC determination through his narrative discussion of the medical evidence and the findings in ALJ Kilbane’s opinion. Although findings

made by the Social Security Administration (“SSA”) in a claimant’s earlier application for benefits will not have preclusive effect as to subsequent applications, *Albright v. Comm’r of Soc. Sec.*, 174 F.3d 473, 476–78 (4th Cir. 1999), an ALJ must “consider such finding[s] as evidence and give [them] appropriate weight in light of all relevant facts and circumstances” in the record before him, SSAR 00-1(4), 2000 WL 43774, at *4 (Jan. 12, 2000) (interpreting *Albright*); *see also Dailey v. Colvin*, No. 4:14cv5, 2015 WL 877376, at *7–8 (W.D. Va. Mar. 2, 2015). In determining what weight to give to a prior finding, the adjudicator must consider (1) whether a fact on which the prior finding was based is subject to change over time; (2) the likelihood that such a change took place, taking into account “the length of time that has elapsed between the period previously adjudicated and the period being adjudicated in the subsequent claim;” and (3) the extent to which evidence not considered in the prior claim “provides a basis for making a different finding with respect to the period being adjudicated in the subsequent claim.” SSAR 00-1(4), 2000 WL 43774, at *4; *see also Dailey*, 2015 WL 877376, at *7.

Newman claims that the medical records during the relevant period do not shed much light on his ability to meet the demands of light work and therefore could not provide a factual basis for the ALJ’s functional analysis. *See* Pl. Br. 6–12. In fact, however, the unremarkable medical record during this period supports the ALJ’s conclusion that Newman’s condition remained largely unchanged prior to November 1, 2012. As the ALJ observed, Newman’s treatment at this time was routine and the medical findings were generally normal. The ALJ could reasonably determine that Newman’s symptoms still supported a finding that he could perform light work until sometime around November 1, 2012, when he began to experience more severe symptoms that were apparently caused by his cirrhosis and chronic alcohol use. Furthermore, the treating physicians’ examination findings and treatment recommendations

provide support for the ALJ's determination that Newman's conditions did not deteriorate before November 1. Thus, it was within the realm of discretion afforded to ALJ Rippel to rely on ALJ Kilbane's opinion. ALJ Rippel's RFC determination logically flows from his detailed discussion of the medical evidence since ALJ Kilbane's previous decision. That medical evidence and previous RFC determination provide sufficient evidentiary support for ALJ Rippel's functional analysis. Furthermore, the record does not contain a functional assessment that is more restrictive than that found by ALJ Rippel.

Newman also claims, however, that the ALJ failed to acknowledge relevant evidence that undermines his RFC determination. He claims that the ALJ should have considered his claim that he uses a nebulizer for about two hours per day. Pl. Br. 11–12. There is, however, no evidence in the record aside from Newman's own testimony⁷ indicating that he was prescribed or needed to use a nebulizer, nor is there any indication that Newman would need to use a nebulizer during the workday. *Cf. Hincer v. Barnhart*, 362 F. Supp. 2d 706, 712–14 (W.D. Va. 2005) (finding that ALJ should have included claimant's need to use a nebulizer where the record clearly showed that a nebulizer had been prescribed and that the claimant needed to use it during the workday).

Newman also points out that the ALJ did not state whether Newman's degenerative back condition was a severe impairment or consider his complaints of back pain during the relevant period. Any error in this regard was harmless, however. Although ALJ Rippel did not directly state whether Newman's back condition was severe, he acknowledged Newman's testimony regarding his back pain, but found it not to be credible. R. 22, 24–25. In addition, he adopted ALJ Kilbane's RFC analysis, which did address Newman's back pain. Furthermore, there is

⁷ Although Newman baldly asserts that his testimony on this issue “must be accepted as true,” Pl. Br. 11, this ignores the fact that the ALJ considered Newman's statements concerning the relevant period to be less than credible.

nothing in the record to suggest that Newman's back pain caused significant problems during the relevant period. There are no objective signs of musculoskeletal or neurological impairments on physical examination or complaints of significant back pain in the subjective portions of the treatment notes.⁸ Newman did not seek out any specialized treatment for his back pain at this time or make any complaints that it limited his functioning.

Although Newman argues that his January 2013 back MRI provides evidence of a disabling back impairment, Pl. Br. 6 (citing R. 1064–65), this argument is unpersuasive. The MRI showed mild to moderate findings, with abutment of the nerve root and moderate stenosis at L4-L5. Furthermore, these findings were assessed by the examining physician to be grossly unchanged in comparison to a 2007 MRI. Rather than bolstering his claim, as Newman suggests, this evidence shows that his degenerative back condition had remained stable during the relevant period. By adopting ALJ Kilbane's RFC analysis, which found that Newman's back pain was not disabling, ALJ Rippel implicitly made a similar finding for the relevant period. The MRI supports this finding.

V. Conclusion

For the foregoing reasons, I find that the ALJ's conducted an adequate RFC analysis and that his RFC determination is supported by substantial evidence. Accordingly, I respectfully recommend that Newman's motion for summary judgment, ECF No. 13, be **DENIED**, 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.

⁸ As the Commissioner acknowledges, Def. Br. 18 n.11, ECF No. 16, back pain was mentioned in the review of systems for some of Newman's primary care visits. R. 461, 632, 699. Nonetheless, these notes do not suggest that Newman experienced any significant difficulty from his back pain, but rather that it simply was one of among several symptoms he experienced during the relevant period.

Notice to Parties

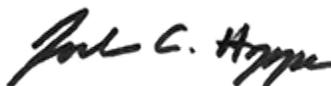
Notice is hereby given to the parties of the provisions of 28 U.S.C. § 636(b)(1)(C):

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 all counsel of record.

ENTER: June 1, 2016



Joel C. Hoppe
United States Magistrate Judge