

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

KEVIN J. SCHANDEL,)	
Plaintiff,)	
)	Civil Action No. 4:14-cv-00042
v.)	
)	<u>REPORT AND RECOMMENDATION</u>
CAROLYN W. COLVIN,)	
Acting Commissioner,)	By: Joel C. Hoppe
Social Security Administration,)	United States Magistrate Judge
Defendant.)	

Plaintiff Kevin J. Schandel asks this Court to review the Commissioner of Social Security’s (“Commissioner”) final decision denying his application for disability insurance benefits (“DIB”) under Title II of the Social Security Act, 42 U.S.C. §§ 401–34. The case is before me by referral under 28 U.S.C. § 636(b)(1)(B). ECF No. 6. Having considered the administrative record, the parties’ briefs, and the applicable law, I find that substantial evidence supports the Commissioner’s decision that Schandel is not disabled.

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); 20 C.F.R. § 404.1505(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); *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

Schandel filed for DIB on April 22, 2011.¹ Administrative Record (“R.”) 93. He was 33 years old at the time, *id.*, and had previously worked as a sanitation engineer on a garbage truck, R. 44–45. Schandel alleged disability beginning May 24, 2004, because of depression and multiple herniated and protruding discs in his spine. R. 93. A state agency denied his claim initially and on reconsideration. R. 93–104, 106–18. Schandel appeared with a non-attorney representative at an administrative hearing on April 23, 2013. R. 42–67. He testified to his medical conditions and the limitations those conditions caused in his daily activities. R. 44–63. A vocational expert (“VE”) also testified about Schandel’s work experience and his ability to return to his past work or to perform other work in the national and local economies. R. 63–66.

The ALJ denied Schandel’s application in a written decision dated May 31, 2013. R. 17–32. He identified Schandel’s date last insured as September 30, 2010. R. 19. He found that through his date last insured, Schandel had severe impairments of degenerative disc disease, a mood disorder, and a history of substance abuse. R. 19–20. He determined that these impairments, alone or in combination, did not meet or equal a listing. R. 20–21. The ALJ next determined that Schandel had the residual functional capacity (“RFC”)² to perform light work³

¹ Schandel previously filed for DIB on February 1, 2007, R. 50, and November 9, 2009, R. 68. His claims were denied, and he did not appeal those decisions further at the time. R. 50–51, 68–78, 80–91. During his administrative hearing, Schandel moved to have his second application reopened. R. 51. The ALJ denied Schandel’s request, and Schandel does not appeal that decision here. R. 17.

² 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); SSR 96-8p, 1996 WL 374184, at *1 (July 2, 1996).

with some postural and environmental restrictions and limited demands for concentration and social interaction or public contact. R. 21–30. Relying on the VE’s testimony, the ALJ concluded that Schandel could not return to his previous work as a sanitation worker, but could perform other jobs available in the economy, such as price marker, garment sorter, and hand packer. R. 30–31. He therefore determined that Schandel was not disabled under the Act. R. 32. The Appeals Council declined to review that decision, R. 1–3, and this appeal followed.

III. Relevant Medical Evidence

A. *Physical Impairments*

Schandel suffered a back injury on May 24, 2004, while trying to lift a heavy object at his job as a sanitation engineer. R. 45, 793. During a neurological consultation on August 25, 2004, he reported mid and low-back pain radiating down his buttocks and thighs, without any numbness, tingling, or bowel and bladder disturbance. R. 793. He was undergoing physical therapy and remained working at that time because he had no other livelihood. *Id.* Schandel had tenderness in his dorsal spine, left scapular region, and left lumbosacral region, as well as decreased range of motion in lateral side bending. R. 794. He had normal pulse, muscle strength and sensation, with some depressed lower extremity reflexes. *Id.* Samson Mebrahtu, M.D., diagnosed lumbosacral and possible thoracic radiculopathy, potentially secondary to herniated discs, with associated myofascial pain syndrome. *Id.* He recommended Schandel continue physical therapy and receive MRIs. *Id.*

³ “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). 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).

On October 1, 2004, Schandel had MRIs taken of his thoracic and lumbar spine. R. 787–88. He had multilevel thoracic degenerative disc disease with small disc herniations resulting in mild spinal cord compression at several levels, R. 787, and degenerative disc disease at L4-L5 and L5-S1 with small broad-based disc herniations without stenosis or nerve root compression, R. 788. There was also a nonspecific finding of a Schmorl’s node at the inferior end plate of L5 with associated edema. *Id.*

At a follow-up appointment with Dr. Mebrahtu on February 1, 2005, Schandel complained of increasing back pain, which had been unresponsive to physical therapy and had left him unable to go to work as of that morning. R. 785. His physical examination was the same as before, and Dr. Mebrahtu referred him for a neurosurgical evaluation and to pain management. R. 786. He stated that Schandel “remains disabled by his current condition,” advised against lifting, bending, or twisting, and prescribed painkillers for symptomatic relief. *Id.*

Schandel visited Philip L. Schrank, M.D., three days later for a second opinion. R. 1012–13. He reported recent episodes of tingling and numbness in his buttocks and upper legs. R. 1012. On examination, he walked with a slight antalgic gait and had difficulty arising from or staying in seated and supine positions. *Id.* He had pain and spasm along his parathoracic and paralumbar musculature and pain to palpation along the iliac crest into the sciatic notch bilaterally with no noticeable swelling. *Id.* He had a positive straight leg raise test bilaterally at 60 degrees and mild left hip flexion weakness, but otherwise full lower extremity strength, intact sensation, and normal reflexes. *Id.* An X-ray taken that day showed narrowing of the L5-S1 disc interval and some straightening of the normal curvature of the lumbar spine. R. 1013. Dr. Schrank recommended that Schandel continue taking anti-inflammatories and muscle relaxants,

added a Vicodin prescription for pain, and encouraged him to see spine and pain-management specialists. *Id.*

On February 18, 2005, Schandel saw Sumeer Sathi, M.D., and reported mid and low back pain with rare radiation to his legs and no associated numbness or tingling. R. 1015. He had a left side positive straight leg raise test at 60 degrees and tenderness over the thoracic spinous processes at T11 and T12 and over the adjacent bilateral facet joints of T11-T12, but full strength and intact sensation throughout his extremities. R. 1015–16. Dr. Sathi concluded that it was “reasonable that he pursue conservative therapy” and referred him to pain management for possible epidural steroid injections. R. 1016.

Schandel had a pain management consultation with Norman L. Chermik, M.D., on March 2, 2005. R. 789–92. He reported progressively worsening pain, limited activities of daily living, and total disability. R. 789. On physical examination, he had tenderness throughout his upper and lumbar back, some left hip instability with a range of motion deficit, and an altered gait secondary to bilateral foot pronation and hallux flexion restriction. R. 791. He had normal reflexes and full strength and sensation in his extremities. *Id.* Dr. Chermik recommended a course of acupuncture and possible orthotic correction for his gait. R. 792.

On March 22, 2005, Schandel returned to Dr. Sathi’s office. R. 1017–18. He had positive straight leg raise tests bilaterally at 45 degrees and tenderness to palpation over the L4 and L5 spinous processes, the bilateral L4-L5 facet joints, and at a few points over the paravertebral lumbosacral region. R. 1018. He also had full strength, normal reflexes, and intact sensation in his extremities. *Id.* Meeru Sathi-Welsch, M.D., increased his muscle relaxants, prescribed pain relief patches, and requested lumbar epidural steroid injections. *Id.*

Schandel started pain management treatment with Lawrence Winikur, M.D., on April 25, 2005. R. 568–69. He reported weakness, pain with walking, leg cramps, and joint stiffness, but denied joint pain or swelling. R. 568. He was tender over the lumbar spinous processes and facet joints, but had full strength, normal reflexes, and intact sensation throughout his extremities. R. 569. Dr. Winikur diagnosed thoracic and lumbar degenerative disc disease and gave Schandel an epidural steroid injection at L4-L5. R. 559, 569.

A year later, on April 11, 2006, Dr. Winikur gave Schandel an epidural steroid injection at T6-T7. R. 582. On July 17, 2006, Dr. Winikur gave Schandel another injection at L4-L5. R. 557, 572.

Schandel had MRIs taken of his thoracic and lumbar spine on September 1, 2006. R. 456, 460. The former showed degenerative disc disease in two locations: at T7-T8 with mild narrowing of the central canal and at T6-T7 with mild disc bulging, moderate canal narrowing, and very slight deformity of the thoracic spinal cord. R. 460. The latter showed degenerative facet disease at L3-L4, L4-L5, and L5-S1, and degenerative disc disease at L4-L5 and L5-S1 with mild central disc bulging, but only minimal narrowing of the central canal and no definite nerve root compression. R. 456. Dr. Winikur reviewed both MRIs on September 5, 2006. R. 561. Noting that Schandel was not getting dramatic relief from epidural injections, he recommended consultation with a neurosurgeon. *Id.*

Schandel returned to Dr. Winikur on January 16, 2007, to receive a lumbar X-ray and discogram, which demonstrated a torn annulus at L4-L5. R. 457, 462, 465. Shortly thereafter, on February 5, 2007, Schandel had a consultation with neurosurgeon James M. Vascik, M.D. R. 454–55. On examination, he had significant paraspinous muscle spasm in his lumbosacral spine and back pain on bilateral straight leg raising at 70 degrees. R. 455. He could walk on heels and

toes, squat and rise, and had full sensation and reflexes. *Id.* Dr. Vascik thought that his recent thoracic MRI showed minor bulging of no significance and his recent lumbar MRI showed some degenerative changes, but no destructive process and no lateralization or nerve root compression. *Id.* His discogram, however, showed a very pronounced tear centrally, with leakage of the contrast material at L4-L5. Dr. Vascik recommended a bilateral L4-L5 discectomy to repair this tear. *Id.*

At his next appointment with Dr. Winikur on February 27, 2007, Schandel reported that he was scheduled for lumbar surgery. R. 519. On review of his symptoms, he stated that he could walk less than a mile and used a cane; this information remained unchanged on every treatment note from Dr. Winikur thereafter. R. 521. On examination, he had tenderness bilaterally over his facet joints and lower lumbar spine, with full strength, sensation, and reflexes in his extremities. *Id.* Schandel was prescribed Percocet, Lunesta, and Cymbalta. *Id.*

On March 9, 2007, Dr. Vascik performed a bilateral L4-L5 discectomy. R. 445–47. Schandel tolerated the procedure well and was sent to recovery in good condition. R. 446. When Schandel had his sutures removed on March 16, he complained of bilateral buttocks pain and stated that he had cleaned a floor on his hands and knees the day after the surgery. R. 443. Dr. Vascik told him to halt that type of activity, but continue walking and using stairs. *Id.* On March 29, 2007, Schandel had some pain and tenderness around his incision, but no leg pain, radicular pain, pain on straight leg raising, or definite weakness. R. 442. Dr. Vascik wrote that Schandel was not following instructions, citing Schandel's report that he was carrying a five gallon bucket of water within a few days of surgery. *Id.* By May 7, he continued to improve, but also continued to have pain. R. 439. After a flare of pain the previous week that resolved, he still had lower back ache and a lot of upper back pain. *Id.* Dr. Vascik noted that he walked well with excellent lower

extremity power, but was still very tender to palpation near his incision and along his paraspinous muscles. *Id.*

Schandel saw Dr. Winikur on June 5, 2007. R. 523. He had recently fallen down a set of stairs and reported aching in his neck, bruising across his back, and radiating left lumbar pain from the back of his left leg to his knee. *Id.* On examination, he had tenderness bilaterally across his facet joints and thoracic spine, intact sensation and reflexes, and full strength in his extremities, though it was influenced by pain. R. 525. Dr. Winikur assessed lumbar degenerative disc disease, chronic lumbar pain that was stable and slightly improved since surgery, stable intermittent lumbar radiculopathy, and acute exacerbation of thoracic spine pain. *Id.* These physical findings on exam and Dr. Winikur's assessment remained unchanged in every treatment note that contained those sections thereafter. At Schandel's request, R. 523, Dr. Winikur administered facet joint blocks bilaterally at T9-T10, T10-T11, and T11-T12. R. 510.

On June 11, Schandel had his last appointment with Dr. Vascik, and he reported experiencing bad lower back pain after falling two weeks previously. R. 438. Dr. Vascik found no motor, sensory, reflex, or range of motion deficit, but Schandel had "very severe" muscle spasm in his lumbosacral spine. *Id.* Physical therapy was not helping, and Dr. Vascik proposed chiropractic care. *Id.* He twice emphasized that Schandel hurts. *Id.* Dr. Vascik concluded that he may not be able to help him and recommended he continue with pain management. *Id.*

Schandel returned to Dr. Winikur on July 13, 2007, reporting that he was still getting relief from the June 5 thoracic injections, but also had lower back pain radiating down both legs into his calves. R. 526. Dr. Winikur recommended chiropractic care. R. 528.

Schandel started chiropractic therapy with Glenn M. Stark, D.C., on August 7, 2007. R. 469-76. He reported pain radiating through his middle back, lower back, buttocks and thighs,

with occasional leg pain. R. 469. On a back pain disability questionnaire, Schandel indicated that his pain was severe and constant, preventing him from sitting or standing more than one hour and walking more than one mile at a time. R. 472. He could lift only very light weights and got less than half a normal night's sleep. *Id.* Pain also restricted his social life and compelled him to seek alternative forms of travel. *Id.* An X-ray showed moderate osteoarthritis at L5-S1. R. 475. Schandel visited Stark eight times between August 8, 2007, and September 7, 2007, R. 476–84, but also missed appointments on August 22 and 29, R. 485. After he missed a third appointment on September 13, Stark discontinued care. R. 483.

Schandel returned to Dr. Winikur on September 7, 2007. R. 529. He had mid and lower back pain that radiated down both legs to his calves, but Percocet took the edge off his pain. *Id.* He reported that the June facet joint injections were beginning to wear off and asked to be scheduled for another round. *Id.* Dr. Winikur refilled his medications and scheduled him for injections. *Id.*

On October 16, 2007, Schandel reported bilateral thoracic pain without tingling or numbness. R. 532. Staying in one position, heavy lifting, and, at times, coughing or sneezing increased his pain, while changing positions frequently helped alleviate it. *Id.* He stated that Percocet was working well for him. *Id.* Dr. Winikur administered another round of thoracic facet blocks on November 30, 2007. R. 558.

Schandel saw Dr. Winikur five times in 2008. *See* R. 565 (February 11), 535 (March 3), 538 (July 28), 541 (August 26), 562 (October 29). He consistently reported mid and lower-back pain radiating into his legs. He said that Percocet helped when he took it and he experienced increased pain when he ran out. *See* R. 565, 538, 562. Dr. Winikur provided at least three sets of facet injections, which each provided two to three weeks of relief. R. 535, 538, 541. Schandel

reported no changes in his health since previous visits, physical examination findings remained identical to previous visits, and Dr. Winikur's assessment remained the same as in the year before. *See* R. 535–43, 562–67.

Dr. Winikur wrote a letter on February 29, 2008, in response to an inquiry from plaintiff's counsel. R. 831–32. He opined that Schandel was “permanently and totally disabled,” and unable “to return to work in any vocation.” R. 831. The best pain management had been able to do was “control a small portion of his chronic pain” to allow him “to perform activities of daily living and provide self care for himself.” *Id.* Dr. Winikur based his conclusion on Schandel's severe and chronic pain, his diagnosis of degenerative disc disease, and the diagnostic evidence of 6 bulging discs in his thoracic and lumbar spines. R. 831. He also concluded that Schandel's inability to work contributed to his depression and mental instability. Dr. Winikur opined that Schandel had not received proper medication for his conditions and the lack of proper treatment led to his aberrant and erratic behavior and legal issues. R. 831–32.

Schandel also visited the emergency department four times in 2008. On March 12, 2008, he was treated for a sprained ankle sustained when “he stepped off a garbage container platform,” R. 914, a few days before. R. 908–21. He was given pain medication and a Return to Work form stating he should be non-weight bearing until he saw an orthopedist. R. 919–20. On March 20, Schandel reported to the emergency department vomiting blood. R. 862–77. He was diagnosed with an “upper gastrointestinal bleed secondary to [an] esophageal ulcer and gastritis secondary to nonsteroidal anti-inflammatory drug abuse, alcohol use, and smoking.” R. 868. The attending physician instructed him to take only Tylenol and follow up in two weeks. *Id.* On May 8, Schandel received treatment after an altercation. R. 878–89. He had been pepper sprayed by police and had swelling around his right jaw and ear, a laceration on his right eyebrow, and

abrasions on his left elbow and great toe. R. 878, 886. Finally, on September 23, 2008, he was treated for a swollen right hand after he punched a wall. R. 890–98. An X-ray showed no acute fracture or destructive lesion. R. 893. There is no evidence that any of these injuries developed into a lasting condition.

In 2009, Schandel saw Dr. Winikur four times. *See* R. 544 (February 25), 547 (June 10), 550 (September 28), 553 (November 24). He was incarcerated at Henry County Jail during this year, *id.*, and reported that his worker’s compensation had dropped him when he was incarcerated, R. 544. On February 25, 2009, he reported that he had received one month of relief from the August 28, 2008, lumbar facet joint injections and that his current combination of Cymbalta and Percocet was not as effective as it previously had been. R. 544. Dr. Winikur adjusted the dosage of his Percocet, R. 546, and Schandel reported the medications were “moderately effective,” R. 547, and “effective,” R. 550, though he was concerned over the cost, R. 547. When Schandel ran out of Percocet or was placed on a different set of medications, he reported decreased effectiveness and increased pain. R. 550, 553. Dr. Winikur recorded the same findings on physical examination and assessment as he had the previous two years. *See* R. 545–46, 549, 552, 555. Dr. Winikur administered another round of bilateral lumbar facet joint injections on November 24, 2009. R. 555, 570.

On December 4, 2009, G. Sam Samarasinghe, M.D., performed an independent medical examination of Schandel for the State of New York Worker’s Compensation Board. R. 963–68. Schandel told Dr. Samarasinghe that his 2007 surgery had increased rather than alleviated his pain, R. 965, and he reported fatigue, weight gain, and numbness and weakness in his legs. R. 966. On examination, Schandel had a slow gait and moved with pain when changing posture. R. 966. He had mild paraspinal tightness with restriction in range of motion in all parameters. *Id.*

He was tender to palpation across his SI joints and sciatic notch. *Id.* He demonstrated some weakness of the proximal muscles and trace weakness of the left foot extensor compared to the right. *Id.* He was symptomatic on straight leg raising at 40 degrees. *Id.* Reflexes in his knees were normal, but Dr. Samarasinghe could not elicit reflexes in his ankles. *Id.* Schandel had no clonus or sensory deficits in his extremities. *Id.*

Based upon this examination and his review of the medical record, Dr. Samarasinghe diagnosed extensive thoracic and lower lumbar degenerative disc disease with a poor prognosis. R. 967. When evaluating Schandel's past treatment, he opined that the lumbar discectomy had been the wrong surgery and that Schandel needed a "total discectomy with 360 degree fusion to have any chance of therapeutic success." *Id.* As to what further treatment was needed, he concluded that

"Due to unresolved pain, chronic pain behavior, and the psychological derangement due to the length of his disability, he would be a poor candidate for additional surgeries. However, with optimized pain control, psychological supportive care, and psychiatric interventions, he may be retrained and rehabilitated in some type of sedentary work activity in the future. Although the probability of this scenario is very low in my opinion."

Id. Dr. Samarasinghe recommended radiofrequency facet denervation⁴ and close monitoring for any myelopathic symptoms, which he indicated would change his suggestion and necessitate immediate surgical evaluation. *Id.* He found that Schandel was unlikely to recover fully and had therefore achieved permanent partial disability. *Id.*

⁴ Radiofrequency denervation, or radiofrequency neuronotomy, "is a procedure to reduce back and neck pain [wherein h]eat generated by radio waves is used to target specific nerves and temporarily interfere with their ability to transmit pain signals." Mayo Clinic, *Radiofrequency Neuronotomy: Definition*, Nov. 26, 2014, <http://www.mayoclinic.org/tests-procedures/radiofrequency-neuronotomy/basics/definition/prc-20013452>.

When Schandel returned to Dr. Winikur on January 27, 2010, he reported back pain radiating to his lower extremities and tingling in his left leg down to the foot. R. 579. His current medications of Cymbalta and Flexeril were effective, and he received some relief from the November 24, 2009, lumbar facet joint injections. *Id.* Dr. Winikur's examination findings and assessment were the same as before. R. 581. He gave Schandel bilateral lumbar facet joint injections, which he stated were authorized by worker's compensation.⁵ R. 581, 571. He also opined that radiofrequency denervation was medically necessary. R. 581.

Dr. Winikur performed radiofrequency denervation of Schandel's left lumbar facet joints on June 10, 2010. R. 637–38. At the corresponding appointment, Schandel again reported back pain radiating to his lower extremities and tingling in his left leg down to the foot and also stated that his current regime of Cymbalta, Lortab, and Flexeril was not effective. R. 638. Dr. Winikur noted that "he has failed all conservative treatment in the past including physical therapy and [non-steroid anti-inflammatory drugs]." *Id.*

Dr. Winikur wrote another letter at the request of claimant's counsel on June 12, 2010. R. 804–05. He recounted Schandel's treatment history of injections, a discogram, and pain medications. Dr. Winikur again opined that Schandel is "completely and permanently and totally disabled from all and any vocations . . . due to his chronic pain, depression, and treatment with psychoactive medications and their side effects." R. 805. He added that Schandel "is at risk in any workplace due to his impairments in mobility, concentration, and ambulation." *Id.*

On August 20, 2010, Schandel reported to Dr. Winikur that he had received mild to moderate relief from the left radiofrequency denervation and that his current medication regime was effective. R. 814. Nonetheless, he complained of pain and spasms from his back bilaterally

⁵ It is clear from this note and others that Schandel began to receive worker's compensation again, but there is no explanation in the record of when or why he was reinstated.

to his knees and tingling through his left leg to the foot. *Id.* Dr. Winikur opined that “with his degree of [degenerative disc disease] of his lumbar and thoracic spine he is completely and totally disabled.” *Id.* He also noted that Schandel had been compliant with all medical recommendations, including the doctor’s instructions “not to return to work” or “pursue any vocations.” *Id.* Dr. Winikur performed radiofrequency denervation of Schandel’s right lumbar facet joints on August 25, 2010. R. 813.

On Dr. Winikur’s referral, Schandel saw Jimmie L. Mask, D.C., for chiropractic manipulations and acupuncture treatment from August 11 to October 14, 2010. *See* R. 759–66, 800. Mask summarized his treatment and findings in a letter dated October 13, 2010. R. 800–01. Schandel had limited cervical range of motion and pain on range of motion; tenderness to palpation and muscle spasms in his thoracic and lumbar spine; pain on straight leg raising, neck flexion, and ankle dorsiflexion, but no pain on manipulation of his sacroiliac joint; and normal reflexes bilaterally. *Id.* Mask diagnosed misalignment in the cervical and lumbar spine, degeneration of lumbar intervertebral discs, and a lumbar sprain. R. 801. He remarked that Schandel had shown some improvement in his clinical symptoms and pain after acupuncture and chiropractic manipulations, but nonetheless opined that Schandel’s injuries were permanent and would “restrict his daily activities for the rest of his life.” *Id.*

Though Schandel’s date last insured was September 30, 2010, the record includes treatment notes from Dr. Winikur through November 17, 2011. *See* R. 693–95, 687–89, 700–13, 778–783, 799–891. These treatment notes are largely consistent with previous records.

B. Mental Impairments

On February 27, 2007, Schandel reported an increase in symptoms of depression and anxiety to Dr. Winikur during a pain management appointment. R. 519. Dr. Winikur adjusted his

antidepressant dosage in response. *Id.* In September of that year, Schandel said that Cymbalta was no longer helping his depression. R. 529. Dr. Winikur again adjusted his medications, *id.*, and Schandel reported an improved mood the following month, R. 532, though he again complained of increased depression by his visit on March 3, 2008, R. 535.

While incarcerated, Schandel began receiving care from Piedmont Community Services in October 2008. R. 496. At a psychiatric evaluation with Don S. Tessmann, M.D., on November 21, 2008, Schandel reported that he was depressed, stated he might have bipolar disorder, and related a history of alcohol abuse beginning at age thirteen. R. 501. On evaluation, his speech was organized and coherent. *Id.* He did not have any flight of ideas, loose associations, memory deficits, hallucinations, or suicidal or homicidal ideation. *Id.* He accepted responsibility for his situation and berated himself for lack of control. *Id.* Dr. Tessmann estimated his intellectual ability as normal, probably upper half. *Id.* He diagnosed major depressive disorder and alcohol abuse and sought to rule out bipolar disorder. R. 502. He assessed a Global Assessment of Functioning (“GAF”)⁶ score of 60,⁷ continued Schandel’s Cymbalta, and prescribed additional medication. *Id.*

On December 19, Schandel reported irritability, racing thoughts, and decreased sleep. R. 500. On a mental status exam, he appeared tense, anxious, depressed, and paranoid with a labile affect. *Id.* His medications were adjusted, and one month later he reported they were helping and he was sleeping better, though he was still prone to angry outburst and appeared tense, agitated,

⁶ GAF scores represent a “clinician’s judgment of the individual’s overall level of functioning.” Am. Psychological Ass’n, *Diagnostic & Statistical Manual of Mental Disorders* 32 (4th ed. 2000) (“DSM-IV”). The scale is divided into 10 ten-point ranges reflecting different levels of functioning, with 1–10 being the lowest and 91–100 the highest. *Id.*

⁷ A GAF score of 51–60 indicates “moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).” *DSM-IV* 34.

and angry with a labile affect. R. 499. On February 20, 2009, he was sleeping well with a slightly improved mood, but appeared depressed and anxious with a labile affect. R. 498. He was diagnosed with bipolar disorder in addition to depression. *Id.* In May, he complained of decreased sleep and was angry with a labile affect. R. 497. A transfer summary dated June 1, 2009, stated that Schandel was stable, though occasionally prone to anger and impulsiveness. R. 496.

On August 14, Schandel reported that he had received another fighting charge while in jail and could receive additional time. R. 605. He complained of missing sleep, but jail staff stated he was sleeping most of the morning. *Id.* His mental status was depressed and anxious. *Id.* He was given a GAF score of 55 and his medications were continued. R. 606–07. A month later he reported that he had received eight additional days' imprisonment for his last assault and that he had since been charged with another assault. R. 603. He slept in the morning and occasionally at night, appeared withdrawn, and was assessed a GAF score of 55. R. 603–04. Schandel had three additional appointments in 2009, at which his medications were continued without any further examination or assessment. *See* R. 600–02.

After being released from jail, Schandel began outpatient care with Piedmont Community Services on January 11, 2010. R. 595–600. In an initial assessment, he was diagnosed with depression, bipolar disorder, and substance abuse and given a GAF score of 55. R. 598. He was referred for anger management and continued substance abuse education. R. 600.

On January 12, 2010, Schandel underwent a detailed psychological evaluation by Alan M. Katz, Ph.D., for the State of New York Worker's Compensation Board. R. 971–82. Schandel acknowledged a longstanding history of depression and admitted that he continued to self-medicate with alcohol abuse. R. 977. His daily activities were significantly restricted; he

maintained a sedentary lifestyle of watching television, completing simple chores, and taking care of his dog. *Id.* He also volunteered at a food bank two to three times a week and attended group therapy weekly. *Id.* Throughout the examination, he maintained appropriate eye contact and social engagement with two different examiners. *Id.* Dr. Katz noted that cognitive symptoms associated with chronic pain were generally minimized and Schandel denied mental sluggishness or sedation from pain medications, but endorsed forgetfulness and difficulty in concentration. R. 978. Dr. Katz found that Schandel had “a tendency to magnify his illness.” *Id.* Dr. Katz determined that based upon raw test data, Schandel had a severe mental disorder with traits of acute and longstanding depression and anxiety and “a mixed personality disorder with depressive, avoidant, and antisocial traits;” however, “his level of emotional distress appears to be highly exaggerated at this time.” *Id.* Dr. Katz diagnosed major depressive disorder superimposed on a chronic pain syndrome. R. 979.

Schandel demonstrated escalating pain throughout the day with Dr. Katz, shown by facial expressions, shifting in his chair, and overt complaints. 979. Schandel’s balance was decreased on the left and he struggled with heel-to-toe walking. R. 980. His fine motor skills were quite functional, though he had decreased grip strength bilaterally and he fatigued quickly. *Id.* Schandel demonstrated average to above average intellectual functioning, learning capacity, and educational achievement. R. 979, 981. Dr. Katz opined that

At this point, Mr. Schandel does not appear capable of returning to competitive employment in a position that would demand manual labor, repetitive movement or sustained motor output. However, given his intellectual resources, his preserved cognitive capacities, and his average learning and educational potential, he appears capable of vocational rehabilitation for consideration of a light duty and sedentary position.

R. 982. Dr. Katz concluded that Schandel would benefit from ongoing psychological counseling, but had a reasonable chance of successful work reentry, though he qualified that this prognosis was “very guarded.” *Id.*

Schandel returned to Piedmont Community Services for medication management on January 21, 2010. R. 593–95. He stated that he had been doing well since his release from prison in November and was going to church and volunteering at a food bank. R. 593. His mental status exam was unremarkable and he was given a GAF score of 55. R. 594–95. At an individual therapy session the next day, Schandel reiterated that he was volunteering at a food bank and attending church regularly. R. 592–93. At that session and his next in February, he expressed concern over upcoming court dates related to theft of a CD, his third petty larceny charge, and an assault and battery charge from a fight while he was in jail. R. 590, 592.

Schandel had his April 30, 2010, appointment from jail. R. 614–17. He had been arrested with his father for assault with a baseball bat—“he states he went to get property that was his and a fight started.” R. 614. He complained of difficulty sleeping, but the counselor noted conflicting stories regarding his sleep. *Id.* He demonstrated agitated behavior, grandiose thought content, and generally appeared in worse condition due to being in jail. R. 615, 617. He was assessed a GAF score of 55. R. 616.

On May 19, 2010, Schandel had an appointment with Tracy Lange, N.P. R. 738–40. He reported decreased energy, fatigue, difficulty sleeping, depression, anxiety, stress, and occasional paranoia. R. 739. His speech and mood were normal, and Lange assessed depression and unspecified anxiety. *Id.*

In August, 2010, Schandel informed Piedmont Community Services that he had been out of jail for a week and was interested in continuing outpatient services. R. 685. Nevertheless, he

canceled his next appointment and failed to re-schedule for two months. R. 679–85. When he did return on October 6, 2010, he walked with a cane, having had a procedure for his back the previous day, *see* R. 820, that had yet to afford relief. R. 679. He thought his medications were not working after they were briefly switched. *Id.* He was sleeping during the day rather than at night. *Id.* On examination, he appeared tense, with a depressed, anxious mood and obsessive, paranoid thoughts. R. 680. He was given a GAF score of 55 and his medications were adjusted. R. 681–82.

The record reflects that Schandel continued to receive care at Piedmont Community Services through at least February 22, 2013. *See* R. 923–47.

IV. Discussion

Schandel raises the following arguments on appeal: (1) the ALJ’s credibility finding is legally flawed, (2) the ALJ inappropriately rejected the opinions of Schandel’s treating physician, (3) the ALJ asked the VE an improper hypothetical, and (4) the ALJ failed to consider the State of New York Worker’s Compensation Board’s decision that Schandel was disabled. Schandel Br. 4, ECF No. 18.⁸

A. *Schandel’s Credibility*

The regulations set out a two-step process for evaluating a claimant’s allegation that he is disabled by symptoms, such as pain, caused by a medically determinable impairment. *Fisher v. Barnhart*, 181 F. App’x 359, 363 (4th Cir.2006) (citing 20 C.F.R. § 404.1529). The ALJ must

⁸ Schandel filed a response brief in support of his motion for summary judgment. ECF No. 22. Under Western District of Virginia Local Rule 4(c)(1), parties may only file a second brief at the request of the Court. Schandel did not petition the Court for leave to file his response brief and the Court did not request it. Schandel’s response brief largely consists of arguments rebutting the Commissioner’s brief, but to the extent that it raises new arguments, they are not properly before the Court.

first determine whether objective medical evidence⁹ 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); *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 his 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 his pain “solely because the available objective medical evidence does not substantiate” that description. 20 C.F.R. § 404.1529(c)(2). A claimant’s allegations of pain “need not be accepted 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 [he] suffers.” *Craig*, 76 F.3d at 595. The ALJ must consider all the evidence in the record, including the claimant’s other statements, his daily activities, his treatment history, any medical-source statements, and the objective medical evidence, including “objective medical evidence of pain (such as evidence of reduced joint motion, muscle spasms, deteriorating tissues, redness, etc.).” *Id.* (citing 20 C.F.R. § 404.1529(c)). The ALJ must give specific reasons, supported by explicit relevant evidence in the record, for the weight assigned to the claimant’s statements. *Eggleston v.*

⁹ Objective medical evidence is any “anatomical, physiological, or psychological abnormalities” that can be observed and medically evaluated apart from the claimant’s statements and “anatomical, physiological, or psychological phenomena [that] can be shown by the use of medically acceptable diagnostic techniques.” 20 C.F.R. § 404.1528(b)–(c). “Symptoms” are the claimant’s description of his or her impairment. *Id.* § 404.1528(a).

Colvin, No. 4:12cv43, 2013 WL 5348274, at *4 (W.D. Va. Sept. 23, 2013) (citing SSR 96–7p, at *4).

Ultimately, a reviewing court must defer to the ALJ’s credibility finding except in those “exceptional” cases where the determination is unclear, unreasonable, contradicts other findings of fact, or is based on an inadequate reason or no reason at all. *Bishop v. Comm’r of Soc. Sec.*, 583 F. App’x 65, 68 (4th Cir. 2014) (citing *Edelco, Inc. v. NLRB*, 132 F.3d 1007, 1011 (4th Cir. 1997)); *see also Mascio v. Colvin*, 780 F.3d 632, 640 (4th Cir. 2015).

Schandel correctly points out that the ALJ’s credibility finding appears in a legally flawed, boilerplate statement, R. 28,¹⁰ with “vague and circular” language that “‘gets things backwards’ by implying ‘that [the] ability to work is determined first and is then used to determine the claimant’s credibility.’” *Mascio*, 780 F.3d at 639 (quoting *Bjornson v. Astrue*, 671 F.3d 640, 645 (7th Cir. 2012)). A “claimant’s pain and [RFC] are not separate assessments to be compared with each other.” *Id.* Instead, the RFC must reflect the “extent to which an individual’s medically determinable impairment(s), including any related symptoms, such as pain,” limit his functional ability to perform work-related activities. *Id.* (emphasis omitted). The ALJ “should have compared [Schandel’s] alleged functional limitations from pain to the other evidence in the record, not to [his] residual functional capacity.” *Id.*; *see also* 20 C.F.R. § 404.1529(c)(4). The

¹⁰ The full statement reads:

After careful consideration of the evidence, the undersigned finds that the claimant’s medically determinable impairments could reasonably be expected to produce the alleged symptoms; however the claimant’s statements concerning the intensity, persistence, and limiting effects of these symptoms are credible only to the extent that they are consistent with the above residual functional capacity assessment, for the reasons explained in this decision.

R. 28.

ALJ's reliance on this boilerplate statement is harmless, however, if he properly analyzed Schandel's credibility elsewhere in his written decision. *Mascio*, 780 F.3d at 639.

The ALJ did not rest on the boilerplate statement, but rather provided other, more specific reasons for his credibility determination with citations to support in the record. *See* R. 28–29. Schandel objects to these reasons, arguing that some are not properly relevant and others are unsupported and even contradicted by the record. Schandel Br. 16–18. It is true that the record does not provide uncontroverted support for the ALJ's analysis, and some of Schandel's objections are well taken. Nevertheless, considering the record as a whole, substantial evidence supports the ALJ's decision credibility determination.

The ALJ first states that Schandel's allegations of total debility are not supported by diagnostic testing, which showed only "mild to moderate degenerative changes in the thoracic and lumbar spine." R. 28. Schandel's October 1, 2004, MRIs showed multilevel thoracic degenerative disc disease with small disc herniations resulting in mild spinal cord compression at several levels, R. 787, and degenerative disc disease at L4-L5 and L5-S1 with small broad-based disc herniations without stenosis or nerve root compression, R. 788. His September 1, 2006, thoracic MRI showed degenerative disc disease at T7-T8 with mild narrowing of the central canal and at T6-T7 with mild disc bulging, moderate canal narrowing, and very slight deformity of the thoracic spinal cord. R. 460. His lumbar MRI the same day showed degenerative facet disease at L3-L4, L4-L5, and L5-S1, degenerative disc disease at L4-L5 and L5-S1 with mild central disc bulging, but only minimal narrowing of the central canal and no definite nerve root compression. R. 456. A lumbar X-ray and discogram in January 2007 demonstrated a torn annulus at L4-L5. R. 457, 462, 465. An X-ray on August 7, 2007, showed moderate osteoarthritis at L5-S1. R. 475.

Dr. Winikur provided the most severe interpretation of these diagnostics, stating that “Mr. Schandel suffers from multilevel degenerative disk disease including, but not limited to, at least 6 bulging disks from his thoracic to lumbar spine,” which have “caused Mr. Schandel to have severe, disabling pain since [his] injury.” R. 831. On the other hand, Dr. Vascik expressed concern over the annular tear, which he later performed surgery to address, but stated that beyond that the MRIs showed “some degenerative changes but that is it” and the thoracic MRI in particular “showed minor bulging of no significance.” R. 455. State agency examiner John Sadler, M.D., stated the 2006 MRIs showed mild bulging and moderate central canal narrowing. R. 96. Dr. Samarasinghe interpreted the 2006 MRIs as showing degenerative disc disease in the thoracic spine with mild to moderate central canal narrowing, and degenerative disc and facet disease in the lumbar spine with a possible annular tear at L4-L5. R. 966. Though all physicians did not interpret Schandel’s diagnostic tests as the ALJ did, considering the record as a whole the ALJ’s assessment of mild to moderate degenerative changes has substantial support from the interpretations of both treating and state agency physicians.

The ALJ next states that Schandel’s physical examinations did not find preclusive abnormalities, instead revealing “some tenderness in his spine, [but] no persistent weakness, sensory deficits, or neurologic deficits.” R. 28. Dr. Winikur’s treatment note from February 27, 2007, includes findings from a physical examination, the first in the record by him since Schandel’s initial visit on April 25, 2005. Dr. Winikur’s pertinent findings include pain on back extension, bilateral facet joint tenderness, tenderness in the lower lumbar spine with increased right side tenderness, no muscle atrophy, maintained muscle strength, intact cranial nerves, no pathological reflexes, and intact motor function. R. 521. The next examination findings by Dr. Winikur are from June 5, 2007, and are nearly the same, except that Schandel’s muscle strength

was “maintained but influenced by pain,” and his lower lumbar spine tenderness was replaced with moderate tenderness in his thoracic spine, specifically the left side. R. 525. Thereafter, every single treatment note from Dr. Winikur that contains a physical examination repeats the exact findings of the June 5, 2007 note, in identical language, including repetition of clear typographical errors.¹¹

Physical examinations by other doctors are not in full accord with Dr. Winikur’s notes. Specifically, Dr. Vascik found “very severe” muscle spasm in Schandel’s lumbosacral spine on June 11, 2007. R. 438. Dr. Samarasinghe found on December 4, 2009, that Schandel moved with a slow gait and changed posture with pain, was tender to palpation across his SI joints and sciatic notch, had mild paraspinal tightness with restriction in range of motion in all parameters, was symptomatic on straight leg raising at 40 degrees, demonstrated some weakness of the proximal muscles and trace weakness of the left foot extensor compared to the right, and had normal knee reflexes, but no ankle reflexes that he could elicit. R. 966. Mask found in August 2010 that Schandel had limited cervical range of motion and pain on range of motion, muscle spasms in his thoracic and lumbar spine, normal reflexes, and pain on straight leg raising, neck flexion, and ankle dorsiflexion. R. 800. Dr. Katz found on January 12, 2010, that Schandel had decreased balance on the left and struggled with heel-to-toe walking, had decreased grip strength

¹¹ The full text of the pertinent examination findings is reproduced below, with typographical errors intact:

“Back and Chest: Painful Extension,
Facet Joint TendernessBilateral Other Moderate tenderness to palpation thoracic spine,
specifically left side

...

Neuro: No Muscle Atrophy, Muscle Strength,maintained but influenced by pain Cranial
nerves II-XII intact, No pathological reflexes, , Motor Intact,4 /4DTRs 2 in all, 4 /4,”

See, e.g., R. 525, 528, 530–31.

bilaterally, and demonstrated escalating pain throughout the day, shown by facial expressions, shifting in his chair, and overt complaints. R. 979–80. The ALJ’s summary of examination results does not acknowledge the above findings of spasm, muscle weakness, range of motion deficit, and pain on straight leg raise tests.

These examinations by other doctors, however, also revealed findings that are in line with Dr. Winikur’s notes and support the ALJ’s summary. Dr. Vascik found no motor, sensory, reflex, or range of motion deficits, R. 438, and noted that Schandel walked well with excellent lower extremity power, R. 442. Dr. Samarasinghe found normal knee reflexes and only “some” and “trace” weakness. R. 966. Mask found normal reflexes bilaterally, R. 800, and Dr. Katz found that Schandel’s fine motor skills were overall quite functional, R. 980. Although the ALJ’s depiction of the examination findings is somewhat deficient, it does find some support in the record beyond Dr. Winikur’s treatment notes.

The ALJ next states that with the exception of his March 2007 lumbar discectomy, Schandel’s treatment has been routine and conservative, consisting largely of steroid injections and pain medication, with no additional surgeries recommended or follow-up treatment with a neurologist or orthopedist since he visited Dr. Vascik in May 2007. R. 28. An ALJ may consider any medical treatment taken to alleviate pain when evaluating the applicant’s credibility. *See* 20 C.F.R. § 404.1529(c)(3). Dr. Winikur treated Schandel with pain medication, steroid injections, radiofrequency denervation, and chiropractic referrals. Schandel frequently described his medications as helping to control his pain and conversely reported increased pain when he was unable to take his medication. *See* R. 532, 538, 547, 550, 562, 565, 579. He reported variably a few weeks to a few months of relief from each steroid injection and the denervation. *See* R. 526, 529, 535, 538, 541 544, 579, 814. Dr. Winikur twice recommended chiropractic care, R. 528,

800, which Schandel testified did not provide relief, R. 54, though he stopped attending appointments with Stark, R. 483, and with Mask despite improving at the end of treatment, R. 800. At Schandel's last post-surgical appointment on June 11, 2007, Dr. Vascik opined that he "may not be able to help him" and recommended Schandel continue pain management. R. 438. Two years later, Dr. Samarasinghe thought that Schandel was "a poor candidate for additional surgeries," unless his condition worsened and myelopathic symptoms emerged that would necessitate surgical intervention. R. 967. In multiple instances throughout the record, Schandel's treating physicians characterized his care as conservative.

As the ALJ concluded, the record demonstrates that Schandel received consistent mild to moderate relief from pain medication, steroid injection, and denervation, and that no treating or consulting physician recommended additional surgery after his 2007 discectomy. "[A]n unexplained inconsistency between the claimant's characterization of the severity of [his] condition and the treatment []he sought to alleviate that condition" can weigh against the claimant's credibility. *Mickles v. Shalala*, 29 F.3d 918, 930 (4th Cir. 1994); accord *Dunn v. Colvin*, 607 F. App'x 264, 274–75 (4th Cir. 2015) ("[I]t is well established in this circuit that the ALJ can consider the conservative nature of a claimant's treatment in making a credibility determination . . ."). While there is "no bright-line rule [for] what constitutes 'conservative' versus 'radical' treatment," *Gill v. Astrue*, 3:11cv85, 2012 WL 3600308, at *6 (E.D. Va. Aug. 21, 2012), on this record, the ALJ reasonably concluded that Schandel's treatment primarily consisted of a course he deemed conservative.¹²

¹² During his argument against the ALJ's hypothetical to the VE, Schandel objects to the ALJ's failure to include an ambulatory limitation. Schandel Br. 9–11. This is truly a challenge to the ALJ's credibility determination, as the only definitive evidence that Schandel was prescribed a cane was his testimony. R. 58. Dr. Winikur's notes as early as July 2006 reflect that he reported walking with a cane, R. 552, but do not contain an actual prescription or recommendation for one

The ALJ next lists events and activities in the record that he concludes “appear at odds with a contention of total debility:” volunteering at a food bank, incarceration for grand larceny, fighting in jail, and an assault charge. R. 28–29. Schandel objects to the ALJ’s interpretation of these events, noting that there is no description of the kind of the work he did at the food bank or how strenuous it was, that he was attacked while lying down in jail, and that his crimes and incarceration may not be used to question his credibility by broadly labeling him a bad actor. Pl. Br. 16–19.

At his administrative hearing in 2013, Schandel testified that his recent assault charge resulted from someone attacking him while he was lying down, but this was only the latest of many examples of his involvement in physical violence. In 2008, Schandel visited the emergency department for treatment after an altercation, which left him with swelling around his right jaw and ear, a laceration on his right eyebrow, and abrasions on his left elbow and great toe, R. 878, 886, and for a swollen right hand after he punched a wall, R. 890–98. While in jail in 2009, he was charged with two separate assaults. R. 603. In April 2010, he was incarcerated for assault with a baseball bat after a fight broke out when he went to retrieve property. R. 614. In September 2011, he reported to Nurse Lange that he had been charged with assaulting his girlfriend. R. 725. These incidents are not relevant for their moral implications, but for their

by Dr. Winikur. In 2007, Dr. Vascik stated that after surgery Schandel walked well with excellent lower extremity power. R. 439. Later examinations revealed a “slow gait” in 2009, R. 966, and difficulty with heel-to-toe walking in 2010, R. 979. Once in 2010, Piedmont Community Services noted that Schandel walked with a cane because of a procedure for his back the previous day. R. 679. The medical record contains little direct evidence of Schandel using a cane. The ALJ is correct that there is no prescription for a cane in the record, and some evidence to indicate that Schandel could ambulate without assistance. The ALJ’s RFC and hypothetical to the VE restricts Schandel from climbing, limits him to occasional balancing, and requires him to avoid hazards. The ALJ’s decision to include those restrictions and not to find that Schandel required a cane to walk has substantial support in the record.

demonstration of Schandel consistently engaging in physical altercations, which the ALJ could reasonably find was inconsistent with his claims of severe physical limitations.

Although there is no record of Schandel's exact tasks at the food bank, the record reflects that in January 2010, he not only volunteered at a food bank two to three times a week, but also attended group therapy weekly and went to church regularly. R. 592–93, 977. Additionally, Schandel reported cleaning the floor on his hands and knees and carrying a five gallon bucket of water within a few days of surgery. R. 442–43. Painting a different picture of his abilities, Schandel testified that other than going to the clinic with his wife he mostly stayed in bed watching television. R. 49; *see also* R. 270. His actions and activities contradict his testimony about the severe effects of his impairments. Moreover, during a psychological assessment for the workers compensation claim, Dr. Katz noted that Schandel engaged in symptom magnification, and he had to remind Schandel “about the need to be honest and realistic about the degree of symptom distress he is currently experiencing.” R. 978. Taken as a whole, the record supports the ALJ’s conclusion that Schandel engaged in activities at odds with his claims of debilitating pain.¹³

The ALJ began his credibility analysis with the boilerplate statement that the Fourth Circuit found objectionable. Unlike in *Mascio*, however, the ALJ went on to perform a legally

¹³ Schandel additionally objects to the ALJ’s highlighting of the ankle injury he sustained in March 2008. Schandel Br. 18–19. The ALJ implies, though he does not explicitly find, that Schandel may have returned to his past work as a garbage collector off the record. R. 28–29. In the corresponding emergency department note, Schandel relates that he injured himself “stepp[ing] down off a garbage container platform.” R. 914. The intake form lists that this was not a work-related injury, *id.*, but he was also given a Return to Work form, the only one in the record from his four emergency department visits that year, R. 913. The Court need not resolve this dispute to reach its conclusion. This was one of multiple incidents supporting the ALJ’s conclusion that Schandel engaged in activity beyond his asserted total debility, which was one of multiple factors considered by the ALJ in reaching his credibility finding. The ALJ’s credibility determination has substantial support in the record without the aid of this particular incident or any implications derived from it.

adequate analysis later in his opinion. He articulated a clear list of reasons for his decision that spans four paragraphs and has multiple supporting citations to the medical record. As demonstrated above, while the record contains some evidence that goes against the ALJ's conclusion, it also contains evidence supporting the ALJ's reasoning. Ultimately, the Court must affirm an ALJ's factual findings if "conflicting evidence allows reasonable minds to differ as to whether a claimant is disabled." *Johnson*, 434 F.3d at 653 (quoting *Craig*, 76 F.3d at 589). The ALJ articulated his reasoning and it is supported by substantial evidence. This analysis renders harmless his use of a legally flawed boilerplate statement. *Mascio*, 780 F.3d at 639.

B. Opinion Weight

Schandel contends that the ALJ gave too little weight to the opinion of his treating pain management specialist, Dr. Winikur. *Id.* at 11–14. "Medical opinions" are statements from "acceptable medical sources," such as physicians, that reflect judgments about the nature and severity of the claimant's impairment, including his symptoms, diagnosis and prognosis, functional limitations, and remaining abilities. 20 C.F.R. § 404.1527(a)(2). They are distinct from medical-source opinions on issues reserved to the Commissioner, such as whether the claimant is disabled. *Id.* §§ 404.1527(d)(1), 404.1545(a). The ALJ must consider these opinions as he would any relevant evidence, but he need not accord "any special significance" to the source's medical qualifications. *Id.* § 404.1527(d)(3); *see also Morgan v. Barnhart*, 142 F. App'x 716, 722 (4th Cir.2005) ("The ALJ is not free . . . simply to ignore a treating physician's legal conclusions, but must instead 'evaluate all the evidence in the case record to determine the extent to which [the conclusions are] supported by the record.'" (quoting SSR 96–5p, at *3)).

The regulations classify medical opinions by their source: those from treating sources and those from non-treating sources, such as examining physicians and state-agency medical

consultants. *See* 20 C.F.R. § 404.1527(c). A treating-source medical opinion is entitled to controlling weight if it is “well-supported by medically acceptable clinical and laboratory diagnostic techniques” and “not inconsistent with the other substantial evidence in the record.” *Mastro v. Apfel*, 270 F.3d 171, 178 (4th Cir.2001); 20 C.F.R. § 404.1527(c)(2). If the ALJ finds that a treating-source medical opinion is not entitled to controlling weight, then he must weigh the opinion in light of certain factors including 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. *Burch v. Apfel*, 9 F. App’x 255, 259 (4th Cir.2001) (per curiam); 20 C.F.R. § 404.1527(c)(2). The ALJ must consider the same factors when weighing medical opinions from non-treating sources. 20 C.F.R. § 404.1527(c).

The ALJ must explain the weight given to all medical opinions, *Radford v. Colvin*, 734 F.3d 288, 295–96 (4th Cir.2013), and he must give “good reasons” for the weight assigned to any treating-source medical opinion, 20 C.F.R. § 404.1527(c)(2); *see also Mastro*, 270 F.3d at 178 (the ALJ may reject a treating-source medical opinion “in the face of persuasive contrary evidence” only if he gives “specific and legitimate reasons” for doing so). 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).

Dr. Winikur opined at various times that Schandel is disabled. In a February 2008 letter, he stated that “there is not even a minute doubt that he is permanently and totally disabled,” unable “to return to work in any vocation.” R. 831. He also concluded that Schandel’s inability to work contributed to his depression and mental instability, and his lack of proper medication for these conditions led to his aberrant and erratic behavior and legal issues. R. 831–32. In a

second letter from June 2010, he opined that Schandel is “completely and permanently and totally disabled from all and any vocations . . . due to his chronic pain, depression, and treatment with psychoactive medications and their side effects,” and that he did not expect him to improve. R. 805. He added that Schandel “is at risk in any workplace due to his impairments in mobility, concentration, and ambulation.” *Id.* In August 2010, Dr. Winikur opined that “with his degree of [degenerative disc disease] of his lumbar and thoracic spine he is completely and totally disabled.” R. 814. He also noted that Schandel had been compliant with all medical recommendations, including the doctor’s instructions “not to return to work” or “pursue any vocations.” *Id.* Schandel argues that the ALJ failed to acknowledge the parts of Dr. Winikur’s opinions that did not directly deal with disability, such as his finding of impairments in mobility, concentration, and ambulation. Pl. Br. 13–14.

The ALJ gave Dr. Winikur’s opinions no weight. R. 29. He noted first that they were “conclusory” and “focus[ed] upon the issue of disability, which is expressly reserved to the Commissioner.” *Id.* The ALJ was thus not obligated to grant this portion of Dr. Winikur’s opinions “any special significance,” but should have evaluated them under the standard factors for medical source opinions. 20 C.F.R. § 404.1527(d)(3). Dr. Winikur did not quantify his assessment of Schandel’s limitations in concentration, mobility, and ambulation other than to say that they rendered Schandel disabled. The ALJ accounted for these limitations, although perhaps not to the extent advocated by Dr. Winikur, in his RFC. The ALJ analyzed Dr. Winikur’s opinions based on the record as a whole, concluding that they were “not supported by the longitudinal record, with its limited physical findings and generally routine and conservative treatment, including Dr. Winikur’s own treatment notes.” R. 29. Disparity between Dr. Winikur’s opinions and the objective medical evidence, including his own treatment notes,

provides an adequate basis under the regulations for the ALJ's decision to assign his opinions little or no weight. *See Craig*, 76 F.3d at 590 (substantial evidence supported ALJ's decision to reject treating physician's conclusory opinion where the opinion was not supported by the physician's own treatment notes and was inconsistent with other evidence in the record); *Kersey v. Astrue*, 614 F. Supp. 2d 679, 693 (W.D. Va. 2009) (noting that the ALJ may assign little or no weight to a treating-source opinion "if he sufficiently explains his rationale and if the record supports his findings"). As discussed above, Dr. Winikur's treatment notes consistently reported minimal findings on examination, and the record overall supports the ALJ's conclusions that physical examinations did not find preclusive abnormalities and that Schandel's treatment was largely routine and conservative. Further, the ALJ recounted and evaluated other opinions in the record, granting partial weight to the statements of Dr. Samarasinghe, Dr. Katz, and the state agency physicians. R. 30. Each of those opinions noted limitations that are more in line with the ALJ's assessment that Schandel can perform light work. The ALJ thus went beyond finding Dr. Winikur's opinions conclusory by balancing them against other evidence in the record. He providing specific and legitimate reasons for rejecting them, and the Court finds no fault in his analysis. *Mastro*, 270 F.3d at 178.

C. The ALJ's Hypothetical

Schandel next objects to the formulation of the hypothetical the ALJ posed to the VE. His first objection is based on the Fourth Circuit's holding "that an ALJ does not account 'for a claimant's limitations in concentration, persistence, and pace by restricting [him] to simple, routine tasks or unskilled work.'" *Mascio*, 780 F.3d at 638 (quoting *Winschel v. Comm'r of Soc. Sec.*, 631 F.3d 1176, 1180 (11th Cir. 2011)). Unskilled work "is a term of art, defined by regulation as 'work which needs little or no judgment to do simple duties that can be learned on

the job in a short period of time.” *Fisher*, 181 F. App’x at 364 n.3 (quoting 20 C.F.R. § 404.1568(a)). The term itself tells us little, if anything, about the person’s mental condition, let alone his ability to concentrate on or persist in a task or maintain the pace required to complete even simple tasks in a competitive work environment. *See Mascio*, 780 F.3d at 638. Schandel argues that the ALJ concluded that he had “moderate difficulties” in social functioning and in maintaining concentration, persistence, and pace, R. 21, then failed to account for these difficulties with the limitations in his hypothetical, *see* R. 65; Schandel Br. 8–10.

In *Mascio*, the ALJ asked a hypothetical that only addressed physical restrictions; the sole nod to his previous finding that the claimant suffered from moderate difficulties maintaining concentration, persistence, and pace came from the VE’s unprompted addition of a restriction to “unskilled work.” 780 F.3d at 637–38. In this case, the ALJ’s hypothetical went well beyond just limiting Schandel to unskilled work. The full mental limitations in the hypothetical were:

I’m going to ask you to assume that this person is limited to or is able to handle simple, repetitive tasks. Would be able for the purposes of this hypothetical to sustain concentration on such tasks for two hour segments or within customary work tolerances with breaks, would be able to interact with co-workers and supervisors as needed for task completion, but social interaction demands should generally be minimal and with no more than occasional public contact, and would be able to respond appropriately to change in a routine work setting.

R. 65. These limitations directly match the ALJ’s RFC determination, R. 21, and properly account for his previous findings of moderate limitation. The ALJ did not depend upon the definition of unskilled work to account for difficulties in concentration, persistence, and pace, but rather included a specific limitation on concentration and other restrictions addressing Schandel’s limitations in social functioning. Even so, Schandel argues that the ALJ failed to account for a moderate limitation in persistence and pace. Dr. Winikur discussed Schandel’s concentration, and Schandel does not point to any portion in the record to support this restriction

beyond the limitation in concentration, which the ALJ noted and incorporated into his RFC. Accordingly, the ALJ's limitation to concentrating for two hour periods adequately accounted for any limitation in concentration, persistence, and pace that is supported by the record. The Court is not left to guess how Schandel's moderate limitations "translate into a limitation in [Schandel's] residual functional capacity," *Mascio*, 780 F.3d at 638; the ALJ fashioned a detailed and legally sufficient RFC, which he incorporated into his hypothetical to the VE. *See Baskerville v. Colvin*, No. 3:14cv423, 2015 WL 5786488, at *14 (E.D. Va. Sept. 30, 2015) (upholding RFC with similar mental limitations); *Smallwood v. Colvin*, No. 4:13cv69, 2015 WL 72115, at *13–14 (W.D. Va. Jan. 6, 2015) (upholding RFC with similar mental limitations and hypothetical incorporating it).

D. Worker's Compensation Decision

Finally, Schandel argues that the ALJ erred in failing to "address or even mention the findings" of the State of New York Worker's Compensation Board's decision that Schandel was disabled. Schandel Br. 6. He acknowledges that the ALJ made "sporadic almost accidental reference" to Schandel's worker's compensation claim, but argues that under *Bird v. Commissioner of Social Security Administration*, 699 F.3d 337 (4th Cir. 2012), the ALJ had to pay more "systematic attention" to the other agency's finding of disability.

In *Bird*, the Fourth Circuit acknowledged that regulations require the SSA to make its own decision about a claimant's disability based upon Social Security law, 699 F.3d at 343 (citing 20 C.F.R. § 404.1504), but also noted that the SSA must consider another agency's disability determination as part of its review of the record evidence, *id.* (quoting SSR 06-03p, 2006 WL 2329939, at *6 (Aug. 9, 2006)). Therefore, another agency's decision does not bind the SSA, but it also may not be ignored. *Id.* The Court then specifically evaluated the weight the

SSA should give a Veteran's Affairs ("VA") disability determination, concluding that because the VA decision "resulted from an evaluation of the same condition and the same underlying evidence that was relevant to the decision facing the SSA, . . . the SSA must give substantial weight to the VA disability rating." *Id.* The Court noted, however, that an ALJ may give less weight to a VA rating when the record demonstrates that such a deviation is appropriate. *Id.*

The ALJ's sporadic mention of the worker's compensation claim is reflective of its sporadic presence in the record. Schandel testified that New York had found him totally and permanently disabled, R. 58, and it is clear from passing references in treatment notes that Schandel was receiving worker's compensation by April 2005, R. 568, it was suspended when he was incarcerated in 2009, R. 544, and it was seemingly reinstated by 2010, R. 581. The record does not, however, contain any actual decision from the Worker's Compensation Board reciting the medical evidence and opinions it evaluated, its analysis, or its conclusions.

The record does contain two independent medical consultations performed on behalf of the Worker's Compensation Board—Dr. Samarasinghe's December 2009 examination, R. 963–68, and Dr. Katz's January 2010 examination, R. 971–82—and a letter in support of Schandel's case from Dr. Winikur, R. 804–05. Dr. Samarasinghe concluded that Schandel had achieved moderate permanent partial disability under New York Worker's Compensation guidelines, R. 967; Dr. Katz determined that he was permanently partially mentally disabled, but could potentially return to non-physically demanding work in the future with proper treatment, R. 982; and Dr. Winikur stated that he met and exceeded New York's requirements for Total and Permanent Disability, R. 805. These opinions are as close to an explanation of the contours of

the New York Worker's Compensation Board's decision as the record contains.¹⁴ The ALJ expressly considered these statements, giving the consulting examiners' opinions partial weight and rejecting Dr. Winikur's opinion as discussed previously. R. 30.

Bird instructs courts to consider the similarity between the SSA and another agency's objectives, evidence, and analyses to determine how much weight the SSA should lend that agency's conclusion. 699 F.3d at 343. Without an actual decision from the Worker's Compensation Board detailing its analysis, it is impossible to perform this task or evaluate the Board's decision. The ALJ considered all the evidence in the record, including medical opinions prepared for the Worker's Compensation Board that incorporate its standards. He weighed those opinions, evaluated the entire record, and came to a different decision based upon Social Security law. I find no error in his conclusion.

V. Conclusion

The Court must affirm the Commissioner's final decision that Schandel is not disabled if that decision is consistent with the law and supported by substantial evidence in the record. The Commissioner has met both requirements. Accordingly, I recommend that the Court **DENY** Schandel's motion for summary judgment, ECF No. 17, **GRANT** the Commissioner's motion for summary judgment, ECF No. 20, and **DISMISS** this case from the 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

¹⁴Schandel's submission of the New York Worker's Compensation Board's procedures provides a general framework, but no substance regarding the decision made in his particular case.

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: January 28, 2016

A handwritten signature in black ink that reads "Joel C. Hoppe". The signature is written in a cursive, slightly slanted style.

Joel C. Hoppe
United States Magistrate Judge