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**IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF VIRGINIA
BIG STONE GAP DIVISION**

JOSEPH B. PARSONS,)	
Plaintiff)	
v.)	Civil Action No. 2:12cv00030
)	<u>REPORT AND</u>
)	<u>RECOMMENDATION</u>
CAROLYN W. COLVIN,¹)	
Acting Commissioner of)	
Social Security,)	By: PAMELA MEADE SARGENT
Defendant)	United States Magistrate Judge

I. Background and Standard of Review

Plaintiff, Joseph B. Parsons, (“Parsons”), filed this action challenging the final decision of the Commissioner of Social Security, (“Commissioner”), denying plaintiff’s claims for disability insurance benefits, (“DIB”), and supplemental security income, (“SSI”), under the Social Security Act, as amended, (“Act”), 42 U.S.C.A. §§ 423 and 1381 *et seq.* (West 2011 & West 2012). Jurisdiction of this court is pursuant to 42 U.S.C. §§ 405(g) and 1383(c)(3). This case is before the undersigned magistrate judge by referral pursuant to 28 U.S.C. § 636(b)(1)(B). As directed by the order of referral, the undersigned now submits the following report and recommended disposition.

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

The court's review in this case is limited to determining if the factual findings of the Commissioner are supported by substantial evidence and were reached through application of the correct legal standards. *See Coffman v. Bowen*, 829 F.2d 514, 517 (4th Cir. 1987). Substantial evidence has been defined as "evidence which a reasoning mind would accept as sufficient to support a particular conclusion. It consists of more than a mere scintilla of evidence but may be somewhat less than a preponderance." *Laws v. Celebrezze*, 368 F.2d 640, 642 (4th Cir. 1966). "If there is evidence to justify a refusal to direct a verdict were the case before a jury, then there is "substantial evidence."'" *Hays v. Sullivan*, 907 F.2d 1453, 1456 (4th Cir. 1990) (quoting *Laws*, 368 F.2d at 642).

The record shows that Parsons filed his applications for SSI and DIB on September 22, 2008, alleging disability as of February 24, 2007, due to hypertension, back problems, cholesterol, breathing problems, fatigue and depression. (Record ("R."), at 260-65, 289, 319, 321, 344.) The claims were denied initially and upon reconsideration. (R. at 136-38, 143-45, 149, 152-53, 156-59, 161-62.) Parsons then requested a hearing before an administrative law judge, ("ALJ"). (R. at 163.) Two hearings were held on March 11, 2011, and September 8, 2011, at which Parsons was represented by counsel. (R. at 27-47, 48-79.)

By decision dated September 16, 2011, the ALJ denied Parsons's claims. (R. at 10-21.) The ALJ found that Parsons met the disability insured status requirements of the Act for DIB purposes through March 31, 2012.² (R. at 12.)

² Therefore, Parsons must show that he became disabled between February 24, 2007, the alleged onset date, and March 31, 2012, the date last insured, in order to be entitled to DIB benefits.

The ALJ found that Parsons had not engaged in substantial gainful activity since February 24, 2007. (R. at 12.) The ALJ found that the medical evidence established that Parsons had severe impairments, namely hypertension, obesity, two-level disease of the lumbar spine including disc protrusion and extrusion, obstructive sleep apnea and depressive disorder, not otherwise specified, but the ALJ found that Parsons did not have an impairment or combination of impairments that met or medically equaled one of the listed impairments in 20 C.F.R. Part 404, Subpart P, Appendix 1. (R. at 12-13.) The ALJ found that Parsons had the residual functional capacity to perform simple, routine, repetitive light work³ that required no more than occasional climbing of ramps and stairs, and no climbing of ladders, ropes or scaffolds, that required no more than occasional balancing, kneeling, stooping, crouching and crawling, that did not require him to work around moving machinery, unprotected heights and vibrating surfaces and that did not require him to drive as part of the job. (R. at 14.) The ALJ found that Parsons was unable to perform any of his past relevant work. (R. at 19.) Based on Parsons's age, education, work experience, residual functional capacity and the testimony of a vocational expert, the ALJ found that a significant number of jobs existed in the national economy that Parsons could perform, including jobs as a folding machine operator, a stock clerk/order filler and a food preparer. (R. at 19-20.) Thus, the ALJ concluded that Parsons was not under a disability as defined by the Act and was not eligible for DIB or SSI benefits. (R. at 20.) *See* 20 C.F.R. §§ 404.1520(g), 416.920(g) (2013).

³ Light work involves lifting items weighing up to 20 pounds at a time with frequent lifting or carrying of items weighing up to 10 pounds. If someone can perform light work, he also can perform sedentary work. *See* 20 C.F.R. §§ 404.1567(b), 416.967(b) (2013).

After the ALJ issued her decision, Parsons pursued his administrative appeals, but the Appeals Council denied his request for review. (R. at 1-5.) Parsons then filed this action seeking review of the ALJ's unfavorable decision, which now stands as the Commissioner's final decision. *See* 20 C.F.R. §§ 404.981, 416.1481 (2013). This case is before this court on Parsons's motion for summary judgment filed April 17, 2013, and the Commissioner's motion for summary judgment filed May 22, 2013.

II. Facts

Parsons was born in 1972, (R. at 30, 260, 264), which classifies him as a "younger person" under 20 C.F.R. §§ 404.1563(c), 416.963(c). Parsons obtained his general equivalency development, ("GED"), diploma and has vocational training in culinary arts. (R. at 31, 295.) Parsons has past work experience as a forklift operator, a construction worker and a mechanic and hydraulic pump tester. (R. at 31-33, 290.) Parsons testified at his hearings that he suffered from back and leg pain, sleep apnea, hypertension and chronic obstructive pulmonary disorder. (R. at 33-35, 56, 59.) Parsons stated that, although he had been diagnosed with chronic depression, he did not believe that he suffered from depression. (R. at 36.) Parsons stated that he could walk up to 100 feet without interruption. (R. at 36.) He stated that he could sit for up to 30 minutes without interruption, stand for only a couple of minutes without interruption and lift items weighing up to 30 pounds. (R. at 36-37.)

Vocational expert, Robert Jackson, testified at Parsons's March 2011 hearing. (R. at 72-78.) The ALJ asked Jackson to consider a hypothetical individual of Parsons's age, education and work history, who could perform light

work that did not involve more than concentrated exposure to extreme temperatures, excess humidity, pollutants and irritants, that did not require working around hazardous machinery, unprotected heights, climbing ladders, ropes or scaffolds or working around vibrating surfaces and that did not require driving as a job requirement. (R. at 74.) Jackson testified that a significant number of jobs existed that such an individual could perform, including jobs as a cashier, a mail clerk and an inspector/grader. (R. at 74-75.) Jackson was asked to assume the same individual, but who would be off task 30 to 40 percent of any workday due to absences greater than those that would be allowed to maintain employment. (R. at 75.) Jackson stated that there would be no jobs available that such an individual could perform. (R. at 75.) Jackson also testified that there would be no jobs available for a hypothetical individual who was limited as indicated by Dr. Vorkpor. (R. at 76, 566-68.)

Anne Marie Cash, a vocational expert, also was present and testified at Parsons's September 2011 hearing. (R. at 43-46.) She classified Parsons's past work as a forklift operator as medium⁴ and semi-skilled, his work as a construction worker and heavy equipment operator as heavy⁵ and semi-skilled and his work as a mechanic and hydraulic pump tester as heavy and skilled. (R. at 44.) The ALJ asked Cash to consider a hypothetical individual of Parsons's age, education and work history, who could perform simple, routine, repetitive light work that did not

⁴ Medium work involves lifting items weighing up to 50 pounds at a time with frequent lifting or carrying of items weighing up to 25 pounds. If an individual can do medium work, he also can do sedentary and light work. *See* 20 C.F.R. §§ 404.1567(c), 416.967(c) (2013).

⁵ Heavy work is defined as work that involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. If an individual can do heavy work, he also can do sedentary, light and medium work. *See* 20 C.F.R. §§ 404.1567(d), 416.967(d) (2013).

require working around hazardous machinery, unprotected heights, climbing ladders, ropes or scaffolds or working around vibrating surfaces and that did not require driving as a job requirement. (R. at 44-45.) Cash testified that a significant number of jobs existed that such an individual could perform, including jobs as a folding machine operator, a stock clerk, an order filler and a food prep worker. (R. at 45.) Cash also testified that there would be no jobs available for a hypothetical individual who was limited as indicated by Dr. Vorkpor. (R. at 46, 566-68, 673-75.)

In rendering his decision, the ALJ reviewed records from Wise County Public Schools; Family Drug; Dr. Shirish Shahane, M.D., a state agency physician; Dr. Thomas M. Phillips, M.D., a state agency physician; Wellmont Lonesome Pine Hospital; Greenville Memorial Medical Center; Greenville Free Medical Clinic, Inc.; Wellmont Holston Valley Medical Center; Stone Mountain Health Services; Dr. Kevin Blackwell, D.O.; Dr. Sam G. Vorkpor, M.D.; Robert S. Spangler, Ed.D., a licensed psychologist; Frontier Health; and Elizabeth A. Jones, M.A., a psychological examiner.

On February 27, 2007, Parsons presented to the emergency room at Greenville Memorial Medical Center for complaints of low back pain. (R. at 394-99.) He stated that he slipped and fell while getting out of the shower. (R. at 394.) His blood pressure reading was 228/124. (R. at 392.) Parsons reported a history of hypertension, which was not being treated due to noncompliance with treatment. (R. at 395.) He was in no respiratory distress. (R. at 395.) On March 15, 2007, x-rays of Parsons's lumbar spine showed a slight posterior displacement at the sacrococcygeal junction. (R. at 383.) No acute lumbar fracture was noted, and Parsons's disc spaces were unremarkable. (R. at 383.) On April 20, 2007, an MRI

of Parsons's lumbar spine showed a moderate-sized posterior central disc protrusion at the L4-L5 level and a moderately large posterior central disc extrusion at the L5-S1 level. (R. at 382.)

On March 22, 2007, Parsons was seen at Greenville Free Medical Clinic, Inc., for hypertension and back pain. (R. at 445.) He weighed 374 pounds, and his blood pressure reading was 180/120. (R. at 445.) He was diagnosed with low back pain, hypertension and hyperlipidemia. (R. at 445.) On April 5, 2007, Parsons weighed 379 pounds, and his blood pressure reading was 178/142. (R. at 444.) He complained of back pain, stiffness and spasm. (R. at 444.) Parsons stated that Celebrex was not helping. (R. at 444.) He had limited range of motion, a positive straight leg raising test and spasm. (R. at 444.) He was diagnosed with low back pain and a possible herniated nucleus pulposus, ("HNP"), and an MRI of the lumbar spine was ordered. (R. at 444.) On May 9, 2007, Parsons complained of low back pain and shortness of breath. (R. at 443.) He weighed 385 pounds, and his blood pressure reading was 184/90. (R. at 443.) On June 28, 2007, Parsons complained of back pain with numbness and tingling in his feet. (R. at 442.) It was noted that a CT scan of Parsons's lumbar spine did not show a fracture or HNP. (R. at 442.) He was diagnosed with lower lumbar degenerative disc disease. (R. at 442.) On August 23, 2007, Parsons weighed 390 pounds, and his blood pressure reading was 220/120. (R. at 441.) He was diagnosed with poorly controlled hypertension and morbid obesity and referred immediately to the emergency room. (R. at 440-41.) On August 24, 2007, a sleep study was performed, which showed obstructive sleep apnea. (R. at 435-37, 439.) That same day, an echocardiogram was performed, which showed a trace of mitral regurgitation. (R. at 418-19.) On August 28, 2007, Parsons weighed 382 pounds, and his blood pressure reading was 160/110. (R. at 439.)

On April 20, 2008, Parsons presented to the emergency room at Lonesome Pine Hospital, (“Lonesome Pine”), with complaints of chest pain and shortness of breath. (R. at 376-78, 467-70.) A chest x-ray showed cardiomegaly⁶ and atherosclerotic⁷ aorta. (R. at 379, 483.) Parsons was diagnosed with acute chest pain. (R. at 377.) Parsons was transferred to Wellmont Holston Valley Medical Center, (“Holston Valley”). (R. at 492.)

On October 27, 2008, Parsons presented to the emergency room at Lonesome Pine with complaints of chest pain. (R. at 581-84.) He was diagnosed with acute precordial chest pain. (R. at 582.) He was admitted that same day for nausea and uncontrolled blood pressure. (R. at 578-79.) Chest x-rays showed no acute findings, and an EKG showed normal sinus rhythm. (R. at 579.) Parsons was started on his medications, given a low-salt diet, and his blood pressure was brought down to 138/79 upon discharge on October 28, 2008. (R. at 579.) On November 11, 2008, Parsons presented to the emergency room with complaints of back pain. (R. at 576-77.) He was diagnosed with chronic low back pain. (R. at 577.)

On February 22, 2010, Parsons was admitted to Lonesome Pine for acute respiratory failure secondary to carbon dioxide narcosis from obstructive sleep

⁶ Cardiomegaly is defined as an enlargement of the heart. *See* STEDMAN'S MEDICAL DICTIONARY, (“Stedman's”), 129 (1995).

⁷ Atherosclerosis is defined as a form of arteriosclerosis characterized by the deposition of atheromatous plaques containing cholesterol and lipids on the innermost layer of the walls of large and medium-sized arteries. *See* Stedman’s at 72.

apnea and pickwickian syndrome,⁸ possible pneumonia, morbid obesity, accelerated hypertension and polycythemia.⁹ (R. at 646-48.) A chest x-ray showed cardiomegaly, atherosclerotic aorta and clear lungs. (R. at 641.) He was discharged on February 25, 2010, in improved and stable condition. (R. at 643-45.) Parsons was next hospitalized on January 18, 2011, for shortness of breath and chest pain. (R. at 638-40.) Parsons stated that he had tooth and face pain for the previous two days. (R. at 638.) A chest x-ray showed cardiomegaly and mild pulmonary vascular congestion. (R. at 633.) A CT scan of Parsons's facial bones showed mild mucoperiosteal inflammation of both maxillary sinuses with a small retention cyst in the left maxillary sinus. (R. at 636.) He was discharged on January 19, 2011, with a diagnosis of chest pain, accelerated hypertension and chronic obstructive pulmonary disease. (R. at 637.)

On April 20, 2008, Parsons was admitted to Holston Valley with complaints of chest pain and marked hypertension. (R. at 492-94.) He weighed 360 pounds and reported that he had lost 80 to 100 pounds over the previous year. (R. at 493.) On April 21, 2008, a cardiac study was normal. (R. at 537.) On April 22, 2008, an echocardiogram showed concentric left ventricular hypertrophy, normal global and regional left ventricular systolic function, right ventricular systolic function and no significant valvular disease. (R. at 538-39.) Parsons was discharged on April 22, 2008; however, it was recommended that further hospitalization be considered to optimize blood pressure control. (R. at 489-91.) Parsons reported that he checked

⁸ Pickwickian syndrome is defined as a syndrome characterized by extreme obesity, hypoventilation and general debility. *See* Stedman's at 641.

⁹ Polycythemia is defined as a condition characterized by an abnormal increase in the number of red blood cells in the blood. *See* Stedman's at 655.

his blood pressure at home regularly and that he did well when he took his medication. (R. at 490.)

On April 24, 2008, Parsons was seen by Dr. Paul Augustine, M.D., for complaints of chronic lumbago with occasional radiation down his legs. (R. at 507-09.) Parsons's height was measured at six feet, three inches, and he weighed more than 350 pounds. (R. at 508.) His blood pressure reading was 140/96. (R. at 508.) Examination showed severe tenderness and spasm in the right paralumbar muscle area and positive straight leg raising. (R. at 508.) Parsons was strongly urged to quit smoking as soon as possible. (R. at 508.) Dr. Augustine diagnosed obesity, hypertension, hyperlipidemia, chronic lumbago and sciatica and coronary artery disease. (R. at 507.) On July 22, 2008, Parsons failed a drug screen. (R. at 511.) A letter dated July 23, 2008, to Parsons stated that Dr. Augustine and the physicians at Stone Mountain Health Services would no longer continue to provide him with narcotic prescriptions. (R. at 499.)

On March 9, 2009, Parsons saw Dr. Sam G. Vorkpor, M.D., for complaints of low back pain, uncontrolled blood pressure, anxiety and depression. (R. at 560-61.) His blood pressure reading upon recheck was 165/120, and he weighed 382 pounds. (R. at 560.) His heart had regular rate and rhythm without murmurs or gallops. (R. at 560.) No muscle atrophy or weakness was noted. (R. at 560.) Dr. Vorkpor diagnosed uncontrolled hypertension, sleep apnea, moderate obesity and dental cavities. (R. at 560.) On April 9, 2009, Parsons's blood pressure reading was 190/118, and he weighed 374 pounds. (R. at 559.) On April 23, 2009, Parsons's blood pressure reading was 158/98, and he weighed 380 pounds. (R. at 558.) On May 8, 2009, Parsons reported that his blood pressure continued to be high. (R. at 557.) He complained of dizziness, fatigue and weakness. (R. at 557.) His blood

pressure reading was 162/98, and he weighed 379.4¹⁰ pounds. (R. at 557.) On June 5, 2009, Parsons's blood pressure reading was 160/96, and he weighed 384 pounds. (R. at 556.) On July 17, 2009, Parsons's blood pressure reading was 158/98, and he weighed 391 pounds. (R. at 555.) Dr. Vorkpor reported that Parsons was in no acute distress, but appeared lethargic. (R. at 555.) On August 12, 2009, Parsons weighed 392 pounds. (R. at 554.)

On August 18, 2009, Dr. Vorkpor completed a medical assessment indicating that Parsons could occasionally lift and carry items weighing up to 10 pounds and frequently lift and carry items weighing up to 20 pounds. (R. at 566-68.) He found that Parsons could stand and/or walk a total of 15 minutes in an eight-hour workday and that he could do so for up to 15 minutes without interruption. (R. at 566.) Dr. Vorkpor found that Parsons's ability to sit was not affected. (R. at 567.) He opined that Parsons could occasionally climb, stoop and crouch and frequently kneel, balance and crawl. (R. at 567.) Parsons's ability to push and/or pull was limited due to difficulty breathing. (R. at 567.) Dr. Vorkpor found that Parsons would miss more than two days of work a month due to his impairments. (R. at 568.) Dr. Vorkpor made these findings based on Parsons's diagnoses of sleep apnea, uncontrolled hypertension and morbid obesity. (R. at 567.)

On October 16, 2009, Parsons's blood pressure reading was 116/96, and he weighed 398 pounds. (R. at 587.) Dr. Vorkpor diagnosed uncontrolled hypertension, sleep apnea, chronic back pain and morbid obesity. (R. at 587.) On February 16, 2010, Parsons's blood pressure reading was 188/140, and he weighed

¹⁰ While the treatment note indicates that Parsons weighed 279.4 pounds, this is believed to be a typographical error. (R. at 557.)

414 pounds. (R. at 630.) On April 5, 2010, Parsons reported that he had “been feeling much better.” (R. at 628.) His blood pressure reading was 160/120, and he weighed 401 pounds. (R. at 628.) Dr. Vorkpor reported that, while Parsons still had a problem with blood pressure control, he was “much more improved.” (R. at 628.) On June 7, 2010, Parsons stated that he had been “very much involved in management of his health issues.” (R. at 627.) He reported that he had adjusted his diet, was taking his blood pressure medication as prescribed and had continued to lose weight. (R. at 627.) He reported that he was feeling much better. (R. at 627.) Parsons requested a referral to a psychiatrist, as requested by his attorney, for evaluation of depression. (R. at 627.) On August 6, 2010, Parsons reported that since he started using a sleep apnea mask, his blood pressure had significantly improved. (R. at 626.) He reported taking his medication as prescribed. (R. at 626.) He stated that he felt much better and that “everything seems to be working good.” (R. at 626.) On November 5, 2010, Parsons reported that his then-current medications for his blood pressure were “doing fairly well.” (R. at 625.) His blood pressure reading was 130/98, and he weighed 377 pounds. (R. at 625.) On February 4, 2011, Parsons reported that he was taking his medications as prescribed, losing weight and using his CPAP machine nightly, and he was doing well. (R. at 624.) On May 4, 2011, Parsons reported that he was doing much better since receiving his CPAP machine. (R. at 669.) He stated that he was sleeping better and was able to stay awake more during the day. (R. at 669.) Parsons reported a lot of stress due to a recent death in the family and complications with his disability claims. (R. at 669.) He stated that he felt angry and had racing thoughts due to stress. (R. at 669.) His blood pressure reading was 130/96, and he weighed 350 pounds. (R. at 669.)

On September 6, 2011, Dr. Vorkpor completed a medical assessment indicating that Parsons could occasionally lift and carry items weighing 10 pounds and frequently lift and carry items weighing 20 pounds. (R. at 673.) He reported that Parsons could stand and/or walk a total of 15 minutes in an eight-hour workday. (R. at 673.) Dr. Vorkpor reported that Parsons's ability to sit was not affected by his impairments. (R. at 674.) He reported that Parsons could occasionally climb, stoop and crouch and frequently kneel, balance and crawl. (R. at 674.) He reported that Parsons's ability to push and pull was limited. (R. at 674.) Dr. Vorkpor reported that Parsons would miss more than two days of work per month. (R. at 675.) He based these findings on Parsons's diagnoses of sleep apnea, morbid obesity, back pain and hypertension. (R. at 674-75.)

On April 16, 2009, Dr. Kevin Blackwell, D.O., examined Parsons at the request of Disability Determination Services. (R. at 548-52.) He weighed 378¹¹ pounds, and his blood pressure was 172/112. (R. at 550.) Parsons did not appear to be in any acute distress. (R. at 551.) He was alert, cooperative and oriented with good mental status. (R. at 551.) Parsons's breathing was not labored, and his lungs were clear. (R. at 551.) His heart had regular rate and rhythm without murmurs, clicks or rubs. (R. at 551.) His upper and lower pulses were good and equal bilaterally. (R. at 551.) Parsons's gait was symmetrical and balanced. (R. at 551.) Dr. Blackwell diagnosed probable sleep apnea, chronic low back pain, elevated blood pressure and flatfooted feet. (R. at 551.) Dr. Blackwell opined that Parsons could lift items weighing up to 50 pounds and frequently lift items weighing up to 25 pounds. (R. at 552.) He opined that Parsons could bend and stoop up to two-thirds of the day and squat for up to one-third of the day. (R. at 552.) Dr. Blackwell

¹¹ While the treatment note indicates that Parsons weighed 278 pounds, this is believed to be a typographical error. (R. at 550.)

found that Parsons could not crawl, work at unprotected heights or perform repetitive ladder climbing. (R. at 552.) He found that Parsons could sit for up to eight-hours in an eight-hour workday and that he could stand for up to six hours in an eight-hour workday. (R. at 552.)

On April 22, 2009, Dr. Shirish Shahane, M.D., a state agency physician, indicated that Parsons had the residual functional capacity to perform medium work. (R. at 87-90.) He indicated that Parsons could occasionally climb ramps, stairs, ladders, ropes and scaffolds and occasionally balance, stoop, kneel, crouch and crawl. (R. at 88-89.) No manipulative, communicative or environmental limitations were noted. (R. at 89.) Dr. Shahane reported that Parsons should avoid concentrated exposure to hazards, such as machinery and heights. (R. at 90.)

On October 9, 2009, Dr. Thomas M. Phillips, M.D., a state agency physician, indicated that Parsons had the residual functional capacity to perform medium work. (R. at 118-22.) He indicated that Parsons could occasionally climb ramps, stairs, ladders, ropes and scaffolds and occasionally balance, stoop, kneel, crouch and crawl. (R. at 119.) No manipulative, communicative or environmental limitations were noted. (R. at 119.) Dr. Phillips reported that Parsons should avoid concentrated exposure to hazards, such as machinery and heights. (R. at 120.) This assessment was affirmed by Dr. Robert Stevenson, M.D., another state agency physician, on October 9, 2009. (R. at 122.)

On January 29, 2010, Robert S. Spangler, Ed.D., a licensed psychologist, evaluated Parsons at the request of Parsons's attorney. (R. at 588-93.) Spangler reported that Parsons had no speech problems, but had difficulty completing a sentence due to shortness of breath. (R. at 588.) Parsons demonstrated age-

appropriate fine motor skills, but was awkward in gross motor movements due to morbid obesity and slow gait. (R. at 588.) Parsons's affect was appropriate, and his mood was depressed. (R. at 590.) Parsons reported that he had several friends with whom he frequently visited. (R. at 591.) He reported that he played the drums in a gospel group up to four times a month and that they practiced once a week. (R. at 591.)

The Wechsler Adult Intelligence Scale - Fourth Edition, ("WAIS-IV"), was administered, and Parsons obtained a full-scale IQ score of 92. (R. at 591.) Spangler reported that there was no significant difference between Parsons's verbal comprehension and perceptual reasoning scores; however, these results indicated a decline of 28 points from his previous highest IQ score obtained in the eighth grade and a 25 point decline from his sixth grade IQ score. (R. at 592.) Spangler reported that both exceed a significant drop of 15 points, indicating that listing 12.02 may be equaled or met. (R. at 592.) The Wide Range Achievement Test-4, ("WRAT-4"), was administered, indicating that Parsons's word reading was at the 11.2 grade level, his sentence comprehension score was at the 8.5 grade level and his math computation was at the 6.5 grade level. (R. at 593.) Spangler diagnosed a mild depressive disorder, not otherwise specified; cognitive disorder, not otherwise specified; and average intellectual functioning. (R. at 592.) Spangler assessed Parsons's then-current Global Assessment of Functioning score, ("GAF"),¹² at

¹² The GAF scale ranges from zero to 100 and "[c]onsider[s] psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness." DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS FOURTH EDITION, ("DSM-IV"), 32 (American Psychiatric Association 1994).

60.¹³ (R. at 592.) He opined that Parsons's prognosis was fair with regular mental health treatment. (R. at 592.)

Spangler completed a mental assessment indicating that Parsons had a limited, but satisfactory, ability to follow work rules, to use judgment, to function independently, to maintain attention/concentration, to understand, remember and carry out simple job instructions and to maintain personal appearance. (R. at 594-96.) He opined that Parsons had a seriously limited ability to relate to co-workers, to deal with the public, to interact with supervisors, to deal with work stresses, to understand, remember and carry out detailed instructions, to behave in an emotionally stable manner, to relate predictably in social situations and to demonstrate reliability. (R. at 594-95.) Spangler also opined that Parsons had no useful ability to understand, remember and carry out complex job instructions. (R. at 595.) He found that Parsons would miss more than two days of work a month as a result of his impairments. (R. at 596.)

On December 17, 2010, Parsons was seen for initial screening at Frontier Health with complaints of depression and anxiety. (R. at 619-22.) He reported that he had recently gone through a divorce, lost his mother and had not been able to work due to medical issues. (R. at 621-22.) He reported that he felt depressed because he was not able to work. (R. at 622.) He was provisionally diagnosed with an adjustment disorder with mixed anxiety and depressed mood. (R. at 620.) On January 31, 2011, Parsons returned to Frontier Health for outpatient admission at the referral of his attorney due to depression and anxiety. (R. at 600-18.) He was diagnosed with mild, recurrent, major depressive disorder. (R. at 613.) Parsons's

¹³ A GAF score of 51-60 indicates that the individual has "[m]oderate symptoms... OR moderate difficulties in social, occupational, or school functioning...." DSM-IV at 32.

then-current GAF score was assessed at 60, with his highest score being 60 within the previous six months and his lowest score being 55 within the previous six months. (R. at 613.)

On April 4, 2011, Elizabeth A. Jones, M.A., a psychological examiner, evaluated Parsons at the request of Disability Determination Services. (R. at 659-64.) Parsons reported that he had never been involved in any form of mental health treatment until recently. (R. at 660.) He stated that he began counseling “partially because I was filing for my [d]isability because I have too much time on my hand[s]. I get stupid thoughts about wanting to hurt other people.” (R. at 660.) He stated that he had been a drummer for a gospel band for three years and that the band had produced one album and were in the process of producing a second one. (R. at 660.) Parsons stated that he enjoyed playing the drums, that he was an “amateur magician” and enjoyed artwork. (R. at 661.) He reported that he was a “tattoo artist by trade,” doing tattoos “once in awhile.” (R. at 661.) Parsons reported that his energy level was “medium.” (R. at 662.) Jones diagnosed mild depressive disorder, not otherwise specified and assessed his then-current GAF score at 70,¹⁴ with both his highest and lowest GAF score being 70 within the previous six months. (R. at 663.) Jones completed a mental assessment indicating that Parsons had no limitations on his work-related mental abilities. (R. at 665-67.)

III. Analysis

The Commissioner uses a five-step process in evaluating DIB and SSI claims. *See* 20 C.F.R. §§ 404.1520, 416.920 (2013). *See also Heckler v. Campbell*,

¹⁴ A GAF score of 61-70 indicates "some mild symptoms ... OR some difficulty in social, occupational, or school functioning ... but generally functioning pretty well" DSM-IV at 32.

461 U.S. 458, 460-62 (1983); *Hall v. Harris*, 658 F.2d 260, 264-65 (4th Cir. 1981). This process requires the Commissioner to consider, in order, whether a claimant 1) is working; 2) has a severe impairment; 3) has an impairment that meets or equals the requirements of a listed impairment; 4) can return to his past relevant work; and 5) if not, whether he can perform other work. *See* 20 C.F.R. §§ 404.1520, 416.920. If the Commissioner finds conclusively that a claimant is or is not disabled at any point in this process, review does not proceed to the next step. *See* 20 C.F.R. §§ 404.1520(a), 416.920(a) (2013).

Under this analysis, a claimant has the initial burden of showing that he is unable to return to his past relevant work because of his impairments. Once the claimant establishes a prima facie case of disability, the burden shifts to the Commissioner. To satisfy this burden, the Commissioner must then establish that the claimant has the residual functional capacity, considering the claimant's age, education, work experience and impairments, to perform alternative jobs that exist in the national economy. *See* 42 U.S.C.A. §§ 423(d)(2)(A), 1382c(a)(3)(A)-(B) (West 2011 & West 2012); *McLain v. Schweiker*, 715 F.2d 866, 868-69 (4th Cir. 1983); *Hall*, 658 F.2d at 264-65; *Wilson v. Califano*, 617 F.2d 1050, 1053 (4th Cir. 1980).

By decision dated September 16, 2011, the ALJ denied Parsons's claims. (R. at 10-21.) The ALJ found that the medical evidence established that Parsons had severe impairments, namely hypertension, obesity, two-level disease of the lumbar spine including disc protrusion and extrusion, obstructive sleep apnea and depressive disorder, not otherwise specified, but the ALJ found that Parsons did not have an impairment or combination of impairments that met or medically equaled one of the listed impairments in 20 C.F.R. Part 404, Subpart P, Appendix

1. (R. at 12-13.) The ALJ found that Parsons had the residual functional capacity to perform a limited range of simple, routine, repetitive light work. (R. at 14.) The ALJ found that Parsons was unable to perform any of his past relevant work, but that a significant number of jobs existed in the national economy that he could perform. (R. at 19-20.) Thus, the ALJ concluded that Parsons was not under a disability as defined by the Act and was not eligible for DIB or SSI benefits. (R. at 20.) *See* 20 C.F.R. §§ 404.1520(g), 416.920(g).

In his brief, Parsons argues that the ALJ erred by failing to find that his impairment(s) met or equaled the listing for disorders of the spine, found at 20 C.F.R. Part 404, Subpart P, § 1.04, the listing for sleep-related breathing disorders, found at 20 C.F.R. Part 404, Subpart P, § 3.10 and the listing for affective disorders, found at 20 C.F.R. Part 404, Subpart P, § 12.04. (Plaintiff's Memorandum In Support Of His Motion For Summary Judgment, ("Plaintiff's Brief"), at 6-7.) Parsons also argues that the ALJ erred by failing to give controlling weight to the opinions of Dr. Vorkpor and Spangler. (Plaintiff's Brief at 7-10.)

As stated above, the court's function in this case is limited to determining whether substantial evidence exists in the record to support the ALJ's findings. This court must not weigh the evidence, as this court lacks authority to substitute its judgment for that of the Commissioner, provided her decision is supported by substantial evidence. *See Hays*, 907 F.2d at 1456. In determining whether substantial evidence supports the Commissioner's decision, the court also must consider whether the ALJ analyzed all of the relevant evidence and whether the ALJ sufficiently explained her findings and her rationale in crediting evidence. *See Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 439-40 (4th Cir. 1997).

Thus, it is the ALJ's responsibility to weigh the evidence, including the medical evidence, in order to resolve any conflicts which might appear therein. *See Hays*, 907 F.2d at 1456; *Taylor v. Weinberger*, 528 F.2d 1153, 1156 (4th Cir. 1975.) Furthermore, while an ALJ may not reject medical evidence for no reason or for the wrong reason, *see King v. Califano*, 615 F.2d 1018, 1020 (4th Cir. 1980), an ALJ may, under the regulations, assign no or little weight to a medical opinion, even one from a treating source, based on the factors set forth at 20 C.F.R. §§ 404.1527(d), 416.927(d), if she sufficiently explains her rationale and if the record supports her findings.

Parsons argues that the ALJ erred by failing to find that his impairment(s) met or equaled the listing for disorders of the spine, found at 20 C.F.R. Part 404, Subpart P, § 1.04. (Plaintiff's Brief at 6-7.) Section 1.04 requires that the disorder result in *compromise of the nerve root or the spinal cord* with either (A) evidence of nerve root compression characterized by neuro-anatomic distribution of pain, limitation of motion of the spine, motor loss accompanied by sensory or reflex loss and, if there is involvement of the lower back, positive straight leg raising test; or (B) spinal arachnoiditis, confirmed by an operative note or pathology report of tissue biopsy, or by appropriate medically acceptable imaging, manifested by severe burning or painful dysesthesia, resulting in the need for changes in position or posture more than once every two hours; or (C) lumbar spinal stenosis resulting in pseudoclaudication, established by findings on appropriate medically acceptable imaging, manifested by chronic nonradicular pain and weakness, and resulting in inability to ambulate effectively, as defined in § 1.00(B)(2)(b).

For a claimant to demonstrate that his impairments meet or equal a listed impairment, he must prove that he “meet[s] *all* of the specified medical criteria. An impairment that manifests only some of [the] criteria, no matter how severely, does not qualify.” *Sullivan v. Zebley*, 493 U.S. 521, 530 (1990) (emphasis in original). Here, Parsons’s impairment(s) do not meet or equal § 1.04 because the record reveals no evidence of nerve root compression. On April 20, 2007, an MRI of Parsons’s lumbar spine showed a moderate-sized posterior central disc protrusion at the L4-L5 level and a moderately large posterior central disc extrusion at the L5-S1 level. (R. at 382.) A CT scan showed lower lumbar degenerative disc disease, but no HNP. (R. at 442.) In April 2008, Dr. Augustine diagnosed chronic lumbago and sciatica, but he did not place any limitations on Parsons’s activities. (R. at 507.) In April 2009, Dr. Blackwell noted that Parsons’s gait was symmetrical and balanced. (R. at 551.) He found that Parsons had the residual functional capacity to perform medium work. (R. at 552.) Because there is no objective medical evidence of record showing that Parsons suffers nerve root or spinal cord compromise, he does not meet or equal § 1.04. Thus, substantial evidence supports the ALJ’s failure to find that Parsons’s impairments meet or equal § 1.04.

Parsons argues that the ALJ erred by failing to find that his impairment(s) met or equaled the listing for sleep-related breathing disorders, found at 20 C.F.R. Part 404, Subpart P, § 3.10. (Plaintiff’s Brief at 6-7.) Section 3.10 is to be evaluated under § 3.09 for chronic cor pulmonale or § 12.02 for organic mental disorders. *See* 20 C.F.R. Pt. 404, Subpt. P, App. 1, § 3.10 (2013).

To meet the requirements for § 3.09, a claimant must show that he suffers from irreversible cor pulmonale¹⁵ secondary to chronic pulmonary hypertension as found in § 3.00G, which includes very specific findings of right ventricular overload or failure, with mean pulmonary artery pressure greater than 40 mm Hg or arterial hypoxemia, as described in § 3.02C2. *See* 20 C.F.R. Pt. 404, Subpt. P, App. 1, §§ 3.00G, 3.09 and 3.02C2 (2013).

In October 2008, Parsons was admitted to Lonesome Pine with complaints of chest pain, nausea and uncontrolled blood pressure. (R. at 578-79.) Chest x-rays showed no acute findings, and an EKG showed normal sinus rhythm. (R. at 579.) Parsons was started on medications, given a low-salt diet, and his blood pressure was brought down to 138/79. (R. at 579.) In April 2009, Dr. Blackwell reported that Parsons's breathing was not labored, and his lungs were clear. (R. at 551.) In February 2010, Parsons was admitted to Lonesome Pine for acute respiratory failure secondary to carbon dioxide narcosis from obstructive sleep apnea and pickwickian syndrome. (R. at 646-48.) Chest x-rays showed cardiomegaly, atherosclerotic aorta and clear lungs. (R. at 641.) In April 2010, Parsons reported to Dr. Vorkpor that he had "been feeling much better." (R. at 628.) Dr. Vorkpor reported that, while Parsons still had a problem with blood pressure control, he was "much more improved." (R. at 628.) In June 2010, Parsons reported that he had been "very much involved in management of his health issues" and that he was feeling much better. (R. at 627.) In August 2010, Parsons reported that since he had started using a sleep apnea mask, his blood pressure had significantly improved. (R. at 626.) He stated that he was taking his medications as prescribed and that "everything seems to be working good." (R. at 626.)

¹⁵ Cor pulmonale is defined as an acute strain or hypertrophy of the right ventricle caused by a disorder of the lungs or of the pulmonary blood vessels. *See* Stedman's at 189.

In January 2011, Parsons was admitted to Lonesome Pine for shortness of breath and chest pain. (R. at 638-40.) Chest x-rays showed cardiomegaly and mild pulmonary vascular congestion. (R. at 633.) He was diagnosed with chronic obstructive pulmonary disease. (R. at 637.) However, in February 2011, Parsons reported that he was taking his medications as prescribed, losing weight and using his CPAP machine nightly and was doing well. (R. at 624.) "If a symptom can be reasonably controlled by medication or treatment, it is not disabling." *Gross v. Heckler*, 785 F.2d 1163, 1166 (4th Cir. 1986). Because there is no objective medical evidence of record showing that Parsons suffers from cor pulmonale or chronic pulmonary hypertension, he does not meet or equal § 3.10. Thus, substantial evidence supports the ALJ's failure to find that Parsons's impairments meet or equal § 3.10.

Parson's also argues that the ALJ erred by failing to find that his impairment(s) met or equaled the listing for affective disorders, found at 20 C.F.R. Part 404, Subpart P, § 12.04. (Plaintiff's Brief at 6-7.) To meet the requirements of § 12.04, a claimant must show medically documented persistence, either continuous or intermittent, of four enumerated symptoms of a depressive syndrome, which result in at least two of the following: (1) marked restriction of activities of daily living; (2) marked difficulties in maintaining social functioning; (3) marked difficulties in maintaining concentration, persistence, or pace; or (4) repeated episodes of decompensation, each of extended duration. *See* 20 C.F.R. Pt. 404, Subpt. P, App. 1, §§ 12.04(A)(1), 12.04(B) (2013).

The record shows that Parsons first complained of anxiety and depression in March 2009; however, no diagnosis of anxiety or depression was made at that

time. (R. at 560.) In April 2009, Dr. Blackwell reported that Parsons had good mental status. (R. at 551.) In January 2010, Spangler diagnosed mild depressive disorder, not otherwise specified; cognitive disorder, not otherwise specified; and average intellectual functioning. (R. at 592.) Spangler also noted that Parsons exceeded the 15-point drop in his IQ scores indicating that listing 12.02 may be equaled or met. (R. at 592.) He found that Parsons had a limited, but satisfactory, ability to follow work rules, to use judgment, to function independently, to maintain attention/concentration, to understand, remember and carry out simple job instructions and to maintain personal appearance. (R. at 594-95.) He also found that Parsons had a seriously limited ability to relate to co-workers, to deal with the public, to interact with supervisors, to deal with work stresses, to understand, remember and carry out detailed instructions, to behave in an emotionally stable manner, to relate predictably in social situations and to demonstrate reliability. (R. at 594-95.)

In June 2010, Parsons requested a referral to a psychiatrist, as requested by his attorney, for evaluation of depression. (R. at 627.) In February 2011, Parsons reported that he was doing well. (R. at 624.) In December 2010, Parsons was diagnosed with an adjustment disorder with mixed anxiety and depressed mood. (R. at 620.) In January 2011, he was diagnosed with mild, recurrent, major depressive disorder. (R. at 613.) In April 2011, Parsons stated that he began counseling “partially because I was filing for my [d]isability because I have too much time on my hand[s]. I get stupid thoughts about wanting to hurt other people.” (R. at 660.) He was diagnosed with mild depressive disorder, not otherwise specified. (R. at 663.) No limitations were placed on Parsons’s work-related mental abilities. (R. at 665-67.)

The record does not demonstrate that Parsons had marked restriction of activities of daily living, marked difficulties in maintaining social functioning, marked difficulties in maintaining concentration, persistence, or pace, or repeated episodes of decompensation, each of extended duration. In fact, at his hearing in September 2011, Parsons testified that he did not believe that he suffered from depression. (R. at 36.) Parsons stated that he has several friends with whom he frequently visited. (R. at 591.) He reported that he played the drums with a gospel group up to four times a month, practicing with the band once a week. (R. at 591.) Parsons stated that he enjoyed playing the drums, that he was an “amateur magician” and enjoyed artwork. (R. at 661.) He also stated that he was a “tattoo artist by trade,” doing tattoos “once in awhile.” (R. at 661.) Based on my review of the record, I find that substantial evidence supports the ALJ’s failure to find that Parsons’s impairments meet or equal § 12.04.

Parsons further argues that the ALJ erred by failing to find that his impairment(s) met or equaled the listing for organic mental disorders, found at 20 C.F.R. Part 404, Subpart P, § 12.02. (Plaintiff’s Brief at 6-7.) Under the listed impairment for organic mental disorders found at § 12.02, a claimant is considered disabled if he can demonstrate that he has suffered a 15-point drop in his IQ score and two of the following:

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Marked difficulties in maintaining concentration, persistence, or pace; or
4. Repeated episodes of decompensation, each of extended duration;

20 C.F.R. Pt. 404, Subpt. P, App. 1, § 12.02(A) & (B) (2013).

Although Spangler reported that Parsons exceeded the 15-point drop in his IQ scores, indicating that listing 12.02 may be equaled or met, there is no evidence in the record to demonstrate that Parsons had marked restriction of activities of daily living, marked difficulties in maintaining social functioning, marked difficulties in maintaining concentration, persistence, or pace, or repeated episodes of decompensation, each of extended duration. (R. at 592.) Thus, I find that substantial evidence supports the ALJ's failure to find that Parsons's impairments meet or equal § 12.02.

Parsons also argues that the ALJ erred by failing to give controlling weight to the opinions of Dr. Vorkpor or psychologist Spangler. (Plaintiff's Brief at 7-10.) Based on my review of the record, I find this argument unpersuasive. The ALJ must generally give more weight to the opinion of a treating physician because that physician is often most able to provide "a detailed, longitudinal picture" of a claimant's alleged disability. 20 C.F.R. §§ 404.1527(d)(2), 416.927(d)(2) (2013). However, "circuit precedent does not require that a treating physician's testimony 'be given controlling weight.'" *Craig v. Chater*, 76 F.3d 585, 590 (4th Cir. 1996) (quoting *Hunter v. Sullivan*, 993 F.2d 31, 35 (4th Cir. 1992) (per curiam)). In fact, "if a physician's opinion is not supported by the clinical evidence or if it is inconsistent with other substantial evidence, it should be accorded significantly less weight." *Craig*, 76 F.3d at 590.

Based on my review of the record, I find that substantial evidence exists to support the ALJ's decision to not give controlling weight to the opinion of Dr. Vorkpor or psychologist Spangler. The ALJ noted that she was giving little weight to the assessments of Dr. Vorkpor and Spangler because they were inconsistent with their own clinical findings, as well as the other evidence of record. (R. at 19.)

The ALJ noted that she was giving greater weight to the physical assessment of Dr. Blackwell and the state agency physicians, as well as to Dr. Sandifer, Dr. Turner, Dr. Augustine and psychologist Whitehead¹⁶ because they were consistent with the evidence of record as a whole. (R. at 19.) In addition, the ALJ noted Parsons's activities of daily living. (R. at 18.) Based on this, I find that the ALJ properly weighed the medical evidence and that substantial evidence exists to support the ALJ's finding with regard to Parsons's residual functional capacity. Therefore, I find that substantial evidence supports the ALJ's finding that Parsons is not disabled and not entitled to DIB and SSI benefits.

PROPOSED FINDINGS OF FACT

As supplemented by the above summary and analysis, the undersigned now submits the following formal findings, conclusions and recommendations:

1. Substantial evidence exists in the record to support the ALJ's decision that Parsons's impairments did not meet or equal listing § 1.04 for disorders of the spine;
2. Substantial evidence exists in the record to support the ALJ's decision that Parsons's impairments did not meet or equal listing § 3.10 for sleep-related breathing disorders;
3. Substantial evidence exists in the record to support the ALJ's decision that Parsons's impairments did not meet or equal listing § 3.02 for chronic pulmonary insufficiency;
4. Substantial evidence exists in the record to support the ALJ's decision that Parsons's impairments did not meet or equal

¹⁶ Psychologist Diane L. Whitehead, Ph.D., assisted in the completion of the psychological evaluation of Parsons performed by psychologist Jones in April 2011. (R. at 659-67.)

listing § 3.09 for cor pulmonale secondary to chronic pulmonary vascular hypertension;

5. Substantial evidence exists in the record to support the ALJ's decision that Parsons's impairments did not meet or equal listing § 12.04 for affective disorders;
6. Substantial evidence exists in the record to support the ALJ's decision that Parsons's impairments did not meet or equal listing § 12.02 for organic mental disorders;
7. Substantial evidence exists in the record to support the ALJ's weighing of the medical evidence;
8. Substantial evidence exists in the record to support the ALJ's finding with regard to Parsons's residual functional capacity; and
9. Substantial evidence exists in the record to support the ALJ's finding that Parsons was not disabled under the Act and was not entitled to DIB and SSI benefits.

RECOMMENDED DISPOSITION

The undersigned recommends that the court deny Parsons's motion for summary judgment, grant the Commissioner's motion for summary judgment and affirm the Commissioner's decision denying benefits.

Notice to Parties

Notice is hereby given to the parties of the provisions of 28 U.S.C.A. § 636(b)(1)(C) (West 2006 & Supp. 2013):

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 James P. Jones, United States District Judge.

The Clerk is directed to send certified copies of this Report and Recommendation to all counsel of record at this time.

DATED: This 11th day of October 2013.

/s/ Pamela Meade Sargent
UNITED STATES MAGISTRATE JUDGE