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

WILLIAM CURTIS CAMPBELL, JR.,	)	
Plaintiff	)	
	)	
v.	)	Civil Action No. 2:12cv00040
	)	**REPORT AND**
	)	**RECOMMENDATION**
CAROLYN W. COLVIN,	)	
Acting Commissioner of Social Security,	)	By: PAMELA MEADE SARGENT
Defendant	)	United States Magistrate Judge

I. Background and Standard of Review

Plaintiff, William Curtis Campbell, Jr., filed this action challenging the final decision of the Commissioner of Social Security, ("Commissioner"), determining that he was not eligible for supplemental security income, ("SSI"), under the Social Security Act, as amended, ("Act"), 42 U.S.C.A. § 1381 *et seq*. (West 2012). Jurisdiction of this court is pursuant to 42 U.S.C. § 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.

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 Campbell protectively filed his application for SSI on April 16, 2009, alleging disability as of September 30, 2005, due to problems with his back and legs, broken ribs, chronic obstructive pulmonary disease, ("COPD"), anxiety, depression, numbness in the right leg, herniated discs, bulging discs, lower back problems and high cholesterol. (Record, ("R."), at 15, 154-59, 167, 171.) The claims were denied initially and on reconsideration. (R. at 15, 84-86, 89-90, 92-94, 96-98.) Campbell then requested a hearing before an administrative law judge, ("ALJ"). (R. at 99.) The hearing was held on June 17, 2011, at which Campbell was represented by counsel. (R. at 33-63.)

By decision dated July 18, 2011, the ALJ denied Campbell's claim. (R. at 15-28.) The ALJ found that Campbell had not engaged in substantial gainful activity since April 16, 2009, the date of his application. (R. at 17.) The ALJ determined that the medical evidence established that Campbell suffered from severe impairments, including degenerative disc disease of the lumbosacral spine and borderline intellectual functioning, but he found that Campbell did not have an impairment or combination of impairments listed at or medically equal to one listed at 20 C.F.R. Part 404, Subpart P, Appendix 1. (R. at 17-21.) The ALJ found that Campbell had the residual functional capacity to perform unskilled, sedentary

work[1] that required the performance of no more than occasional postural activities, and which did not require climbing ladders, ropes or scaffolds or working around vibration, respiratory irritants, hazards and unprotected heights. (R. at 22.) Thus, the ALJ found that Campbell was unable to perform any of his past relevant work as an assistant service manager, a drywall hanger and finisher, a self-employed produce seller or a truck driver. (R. at 26.) Based on Campbell's age, education, work history and residual functional capacity and the testimony of a vocational expert, the ALJ found that Campbell could perform other jobs existing in significant numbers in the national economy, including jobs as a maintenance worker, a cashier and a telephone clerk. (R. at 26-27.) Therefore, the ALJ found that Campbell was not under a disability as defined under the Act and was not eligible for benefits. (R. at 28.) *See* 20 C.F.R. § 416.920(g) (2013).

After the ALJ issued his decision, Campbell pursued his administrative appeals, (R. at 9-11), but the Appeals Council denied his request for review. (R. at 1-5.) Campbell 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. § 416.1481 (2013). The case is before this court on Campbell's motion for summary judgment filed July 23, 2013, and on the Commissioner's motion for summary judgment filed August 22, 2013.

[1] "Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met." *See* 20 C.F.R. § 416.967(a) (2013).

II. Facts[2]

Campbell was born in 1963, (R. at 38, 154), which, at the time of the hearing, classified him as a "younger person" under 20 C.F.R. § 416.963(c).[3] Campbell obtained his general equivalency development, ("GED"), diploma and has some vocational training in auto body work. (R. at 38-39.) He last worked full-time in September 2005 as a delivery truck driver and a self-employed produce seller. (R. at 39-40.) Campbell testified that he stopped working when he was involved in a motor vehicle accident. (R. at 39.) He testified that he began seeing Dr. G.S. Kanwal, M.D., following the accident, and he continued to be his treating physician. (R. at 41-42.) Campbell stated that the accident had resulted in seven broken ribs, which caused continuing left side pain, a ruptured spleen, a lung contusion or puncture, two bulging discs, a herniated disc and a tear in the annulus of his back. (R. at 43, 52.) Campbell also testified that he suffered from COPD. (R. at 43.) He stated that his right leg would give way, and he had radiating pain down his right leg. (R. at 43.) Campbell also stated that he had a "real bad nerve problem now." (R. at 43.) He testified that he had abdominal pain due to removal of part of his colon, which had resulted in having to use the restroom at unpredictable times. (R. at 44-45.) Campbell testified that he was able to take care

[2] Because Campbell protectively filed for benefits on April 16, 2009, a determination of disability is relevant as of May 2009, as Campbell could not receive SSI benefits until the month following the month in which he filed his application. *See* 20 C.F.R. § 416.335 (2013). Thus, the relevant time period for determining disability in this case is May 2009 through July 18, 2011, the date of the ALJ's hearing. To the extent that medical records from dates outside these parameters are included, they are for clarity of the record.

[3] At the time of the ALJ's hearing, Campbell was classified as a "younger person." However, in 2013, Campbell reached 50 years of age, making him "a person closely approaching advanced age" under 20 C.F.R. § 416.963(d).

of his personal hygiene, but that his wife took care of all the housework. (R. at 44-45.) Campbell reported having undergone physical therapy and chiropractic treatment for his ribs and back, noting that, if he did not go to the chiropractor, he could not walk. (R. at 46.) Campbell testified that he had not undergone any steroid injections, but he had used a TENS unit. (R. at 47.) He stated that he "get[s] out and walk[s] around some, and then back to the house." (R. at 47.) He stated that he was taking Lortab, Soma, Celexa, Valium, amitriptyline, Lexapro, a nerve pill, potassium and a fluid pill. (R. at 47-48.) He stated that his feet had been swelling all the way up to his knees, for which he had been hospitalized. (R. at 48.) Campbell testified that his medications affected his memory and gave him constipation. (R. at 48.)

Campbell estimated that he could lift items weighing up to 10 pounds, stand and/or walk for a total of only two hours in an eight-hour workday and sit for a total of only two hours in an eight-hour workday. (R. at 48-49.) He testified that he spent four to five hours daily reclining or lying down. (R. at 49.) Campbell stated that he could not repeatedly bend or stoop, but he had no difficulty using his arms, hands or fingers. (R. at 49-50.) However, he testified that both of his feet swelled, his right leg gave out, and he had a shooting pain down the right leg with numbness. (R. at 50.) He stated that his leg also tingled and burned all the way to his toes. (R. at 50.) Campbell testified that he was thinking about starting to use a cane. (R. at 50.)

Campbell rated his pain level since the accident as being from a five to an eight on a 10-point scale. (R. at 52.) On his better days, he testified that he still did not do much of anything, but on the worse days, he stayed in the recliner, on

the couch or in bed. (R. at 52.) He stated that the pain interfered with his sleeping, leaving him tired during the day, resulting in regular napping. (R. at 52-53.) He stated that he did not want to be around crowds, and he associated only with his wife and parents. (R. at 53.) He stated that his medications helped as long as he stayed away from crowds. (R. at 53-54.)

Gerald Wells, a vocational expert, also was present and testified at Campbell's hearing. (R. at 56-61.) Wells classified Campbell's past work as an assistant service manager as light[4] and skilled, as a laborer as heavy[5] and unskilled, as a self-employed produce seller as medium[6] to heavy and semi-skilled and as a delivery truck driver, as normally performed, as medium and semi-skilled. (R. at 56-57.) Wells testified that a hypothetical individual of Campbell's age, education and work experience, who was limited to unskilled, light work with the performance of occasional postural movements, but who could not climb ladders, ropes or scaffolds and could not work around concentrated exposure to hazards and unprotected heights, could not perform any of Campbell's past relevant work. (R. at 57.) However, Wells testified that such an individual could perform the jobs of a cashier, at both the sedentary and light levels of exertion, a convenience store clerk, at the light level of exertion, and a night office cleaner, at the light level of exertion. (R. at 58.) Wells next testified that, the same hypothetical individual, but

[4] Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of items weighing up to 10 pounds. If an individual can perform light work, he also can perform sedentary work. *See* 20 C.F.R. § 416.967(b) (2013).

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

[6] Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of items weighing up to 25 pounds. If an individual can perform medium work, he also can perform light and sedentary work. *See* 20 C.F.R. § 416.967(c) (2013).

who could perform only sedentary work, with the same postural and environmental limitations, and who also must avoid exposure to excessive vibration and respiratory irritants, could not perform any of Campbell's past work or the jobs previously identified. (R. at 58-59.) However, Wells testified that such an individual could perform the jobs of a dispatcher of maintenance workers, a cashier II and a telephone information clerk, all at the unskilled, sedentary level of exertion. (R. at 59.) Wells next testified that the same hypothetical individual, but who also could work only a low-stress job, which was defined as having no fixed production quota, no hazardous conditions, only occasional decision making and only occasional changes in the work setting, and who could have only occasional or superficial interaction with the public and with co-workers and supervisors, could not perform any jobs. (R. at 60.) Lastly, Wells testified that an individual who could not sustain sufficient concentration, persistence and pace performing unskilled work on a full-time basis, would be precluded from all work. (R. at 60.)

In rendering his decision, the ALJ reviewed records from Dr. Robert McGuffin, M.D., a state agency physician; Julie Jennings, Ph.D., a state agency psychologist; Dr. Brian Strain, M.D., a state agency physician; Richard J. Milan, Jr., Ph.D., a state agency psychologist; Martha Rubenstein, Ph.D.; Norton Community Hospital; Dr. Luciano D'Amato, M.D.; Clinch Valley Medical Center; Dr. Jim C. Brasfield, M.D.; Dr. G.S. Kanwal, M.D.; Highlands Chiropractic & Wellness Center; B. Wayne Lanthorn, Ph.D., a licensed clinical psychologist; and Mountain View Regional Medical Center.

An MRI of Campbell's lumbar spine, dated February 1, 2006, showed a tear in the annulus in the left paracentral region with mild bulging of the disc at the L5-

S1 disc space level, with no disc herniation and no narrowing of the central spinal canal or neural foramina at any level. (R. at 546-47.) On March 24, 2006, Campbell underwent an electromyogram, ("EMG"), and nerve conduction study of the lower extremities at Norton Community Hospital with normal results. (R. at 549.)

Campbell saw Martha Rubenstein, Ph.D., for six visits, between March 21, 2006, through July 7, 2006. (R. at 215-24.) At intake on March 21, 2006, Campbell reported never having received mental health treatment in the past. (R. at 215.) He stated that that the September 2005 motor vehicle accident had resulted in personality changes, causing stress in his marriage and that he was very fearful when driving, which he avoided whenever possible. (R. at 215.) Campbell's affect was generally appropriate, but agitated at times, his mood was much more irritable, insight and judgment were fair, short-term memory was mildly impaired, and concentration was mildly impaired. (R. at 215.) Rubenstein estimated his intelligence to be in the average to low average range. (R. at 215.) Campbell endorsed symptoms of anxiety, including trembling and possible panic attacks. (R. at 215.) Rubenstein noted that Campbell was very hypervigilant when driving and that he avoided people. (R. at 215.) Rubenstein diagnosed Campbell with an adjustment disorder with anxiety and depressed mood and some symptoms of post-traumatic stress disorder, ("PTSD"), and she placed his then-current Global Assessment of Functioning Score at 52.[7] (R. at 216.) Rubenstein recommended

[7] 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). A GAF of 51 to 60 indicates that an individual has moderate symptoms or moderate difficulty in social, occupational or school functioning. *See* DSM-IV at 32.

that Dr. Kanwal consider prescribing a trial of an SSRI and cognitive behavioral treatment of anxiety. (R. at 217.)

Campbell continued to see Rubenstein each month through July 2006. By April 24, 2006, Campbell's mood and affect were anxious, but his cognition, appearance and behavior were within normal limits. (R. at 219.) Rubenstein noted minimal progress since the last session. (R. at 219.) She noted that Dr. Kanwal did not prescribe an SSRI as she had hoped, but did prescribe Librax. (R. at 219.) Campbell's wife described him as very irritable and short-tempered. (R. at 219.) On May 8, 2006, Campbell's mood and affect were flat, dysphoric and irritable, his cognition was fragmented with a preoccupation with pain, behavior was hypoactive, and appearance was within normal limits. (R. at 220.) His progress was described as "up and down" since the last session. (R. at 220.) Rubenstein noted that Dr. Kanwal had prescribed Limbritol with little effect. (R. at 220.) She recommended that Campbell discuss Zoloft or Lexapro with Dr. Kanwal at his next appointment. (R. at 220.) On June 2, 2006, Campbell's mood and affect were within normal limits, his behavior was hypoactive, and his appearance was normal. (R. at 221.) Rubenstein noted good progress since the last session. (R. at 221.) She further noted that Dr. Kanwal had prescribed Lexapro, and both Campbell and his wife stated that he was less irritable. (R. at 221.) Rubenstein recommended that he try driving more to assess his anxiety level and to decrease smoking to aid his physical healing. (R. at 221.) However, on June 19, 2006, Rubenstein noted that Campbell had neither driven nor stopped smoking. (R. at 223.) His wife stated he was improving. (R. at 223.) Rubenstein described his mood as depressed, with a normal and appropriate affect and an intact mental status. (R. at 223.) Rubenstein noted only partial treatment compliance, but further noted that

Campbell was accepting his limitations with less anger. (R. at 223.) On July 7, 2006, Campbell's mood and affect were within normal limits, his cognition was fragmented, as he was preoccupied with his work situation, his behavior was hypoactive, and his appearance was within normal limits. (R. at 224.) Campbell had decreased his caffeine intake and cigarette use. (R. at 224.) Rubenstein reported that Campbell had made good progress since his last visit. (R. at 224.) He was driving short distances a little more and was managing it better than before. (R. at 224.) Rubenstein recommended walking five times weekly, continued driving and continued decreased cigarette use and caffeine intake. (R. at 224.) Both Campbell and his with reported noticeable improvement since beginning Lexapro, including less brooding, less irritability and a bit less anxiety when driving. (R. at 224.)

Dr. G.S. Kanwal, M.D., completed an Attending Physician's Supplementary Statement on September 29, 2006, stating that Campbell was totally disabled based on multiple fractured ribs and back pain due to disc disease. (R. at 541.) Campbell saw Dr. Kanwal[8] from January 8, 2007, through May 9, 2011, for complaints of low back pain, aggravated by bending and exertion, left rib cage pain, left side pain, leg pain and wheezing on exertion. (R. at 391-403, 423-50, 518-20.) Over this time period, he consistently exhibited tenderness to the lower back with decreased range of motion, as well as tenderness to the left rib cage area. (R. at 391, 393, 395, 397-403, 423-50, 518-20.) Dr. Kanwal diagnosed, among other things, chronic low back pain, degenerative disc disease, rib cage pain, diverticulitis, hyperlipidemia, COPD, left chest wall pain, polyarthralgia, possible congestive heart failure, depression and anxiety. (R. at 391, 392, 394, 396-400,

[8] Dr. Kanwal's notes are largely handwritten and very difficult to decipher.

403, 423, 431-33, 435, 438-40, 442-50, 518-20.) He administered several interarticular injections in Campbell's low back and left rib cage area, and he prescribed pain medications. (R. at 391-403, 423-50.) Physical examinations of Campbell also revealed occasional rhonchi of the lungs. (R. at 394, 396-97, 400-02, 424-25, 427, 429-32, 434-37, 440, 442, 444, 449-50.) Dr. Kanwal prescribed medications for Campbell's depression and anxiety.[9] It does not appear that Dr. Kanwal placed any restrictions on Campbell in his treatment notes. However, in a letter dated September 2, 2010, Dr. Kanwal stated that, due to the September 30, 2005, motor vehicle accident, in which Campbell sustained injuries to his ribs, spleen, lung and back, he had tried Campbell on multiple medications, and Campbell had undergone several interarticular injections. (R. at 422.) Dr. Kanwal stated that, despite these treatments, he was unable to control Campbell's pain, and he became depressed as a result of his inability to work and was unable to perform the daily activities he once could. (R. at 422.) Dr. Kanwal stated that Campbell suffered from chronic back pain, a tear in the left annulus paracentral region with mild bulging disc at the L5-S1 disc space level, multiple rib fractures and anxiety and depression. (R. at 422.) He opined that Campbell was totally and permanently disabled from any gainful employment. (R. at 422.)

Dr. Kanwal also completed a physical assessment on March 10, 2011, finding that Campbell could occasionally lift and/or carry items weighing up to 10 pounds, but could lift no amount of weight on a frequent basis. (R. at 451-53.) He based this finding on Campbell's chronic back pain and disc disease, multiple rib fractures with pain, COPD, anxiety and depression. (R. at 451.) He opined that Campbell could stand and/or walk a total of two to three hours in an eight-hour

[9] The court cannot decipher in Dr. Kanwal's records the dates on which he prescribed such medications, but this is documented in Rubenstein's treatment notes. (R. at 219-21.)

day, but could do so for only 30 minutes without interruption. (R. at 451.) He further opined that Campbell could sit a total of four hours in an eight-hour day, but could do so for only 30 minutes to one hour without interruption. (R. at 452.) Dr. Kanwal found that Campbell could never climb, stoop, kneel, balance, crouch or crawl, and that his abilities to reach, to handle and to push and/or pull were affected by his impairments. (R. at 452.) He further found that Campbell could not work around heights, moving machinery, temperature extremes, chemicals, dust, noise, fumes, humidity or vibration. (R. at 453.) He based these findings on Campbell's "bad nerves," COPD and chronic pain. (R. at 453.) Dr. Kanwal opined that Campbell would be absent from work more than two days monthly due to his impairments. (R. at 453.)

Campbell also saw Matthew Jessee, D.C., a chiropractor at Highlands Chiropractic & Wellness Center, from May 22, 2007, to January 18, 2010, with complaints of back pain with radicular pain down the right leg and acute right knee pain. (R. at 408-18.) X-rays dated May 22, 2007, showed early osteophyte formation at the anterior, superior aspects of the L3-L5 vertebral bodies, decrease in disc height at the posterior aspect of the L4 and L5 disc spaces with IVF encroachment at both vertebral levels and pelvic unleveling. (R. at 417.) Jessee diagnosed early degenerative disc disease / spondylosis and possible disc displacement at the L4 and L5 vertebral levels, but he suggested confirmation by an MRI. (R. at 417.) Over the course of his treatment with Jessee, Campbell's condition did not improve. On November 21, 2007, Campbell reported mild low back pain and stiffness and acute right knee pain. (R. at 409.) Palpation revealed LSI subluxation with posterior rotation with joint fixation, and there was spondylosis of the L4 level on the right with reduced motion. (R. at 409.) There

also was joint fixation with spondylosis affecting vertebral segment L5 and tenderness to a degree affecting the right knee. (R. at 409.) Jessee introduced joint mobilization of the right knee, and he manipulated the cervical, thoracic, lumbar and LSI regions. (R. at 409.) Campbell also received unattended electrical muscle stimulation to the lumbar region. (R. at 409.) Jessee opined that Campbell needed continued conservative chiropractic treatment, and he noted that, overall, Campbell's condition was improving greatly. (R. at 409.) He advised Campbell to perform home exercises and to use cold packs. (R. at 409.) Jessee scheduled monthly visits with Campbell, during which time he received the same conservative treatments. (R. at 410-16.)

Campbell was admitted to Norton Community Hospital on September 28, 2008, where Dr. Luciano D'Amato, M.D. performed a laparoscopic endo-assisted right colectomy after complaints of severe right-sided abdominal pain, leukocytosis, nausea and vomiting. (R. at 226-367.) Campbell was diagnosed with a perforated cecum secondary to diverticulitis. (R. at 355.) He was discharged on October 2, 2008, with restrictions against lifting more than 20 pounds. (R. at 226-27, 252.) When Campbell saw Dr. D'Amato on October 9, 2008, for follow up, he reported some mild abdominal distention and some loose stools. (R. at 373-75.) Dr. D'Amato explained this was normal, and he advised him that the pathology was benign, confirming diverticulitis. (R. at 374.) Campbell's incision looked good, and Campbell had stable vital signs. (R. at 375.) His staples were removed, and he was advised to follow up as needed. (R. at 375.) Campbell returned to Dr. D'Amato with concerns regarding his incision site on October 18, 2008. (R. at 377-78.) Dr. D'Amato noted a probable seroma, which

might break and drain, in which case it would then need to be dressed with antibiotic ointment and bandages. (R. at 378.)

November 13, 2009, x-rays of the lumbar spine and pelvis showed lumbar spondylosis with disc displacement, biomechanical alterations of the lumbar spine and pelvic unleveling. (R. at 418.) By January 18, 2010, Campbell complained of acute low back pain, a little worse since his previous visit with Jessee on December 28, 2009. (R. at 415-16.) He also complained of moderately severe low back stiffness, the same as his previous visit. (R. at 415-16.) Physical examination revealed reduced mobility of the LSI on posterior rotation and spondylosis of the L4 segment on the right with segmental fixation. (R. at 416.) Palpation showed joint fixation with spondylosis affecting vertebral segment L5. (R. at 416.) Jessee opined that chiropractic management should continue, as Campbell's condition had not improved. (R. at 416.) Jessee kept his treatment plan unchanged. (R. at 416.)

Jessee completed a physical assessment of Campbell on June 20, 2011, approximately a year and a half after last treating him. (R. at 551-53.) Jessee found that Campbell could lift and/or carry items weighing up to 30 pounds occasionally and up to 15 pounds frequently. (R. at 551.) He found that Campbell could stand and/or walk for a total of four hours in an eight-hour day, but for only 30 minutes without interruption. (R. at 551.) Jessee found that Campbell could sit for five to six hours in an eight-hour day, but for two hours without interruption. (R. at 552.) He found that Campbell could never kneel or balance, but could occasionally climb, stoop, crouch and crawl. (R. at 552.) Jessee found that Campbell's abilities to reach, to feel and to push and/or pull were affected by his impairments. (R. at 552.) He found that Campbell was restricted from working

around moving machinery, temperature extremes and vibration. (R. at 553.) Jessee stated that Campbell needed to be very careful on ladders due to sensation loss down his leg. (R. at 553.) He opined that Campbell would be absent from work more than two days monthly due to his impairments. (R. at 553.)

Campbell saw Dr. Jim C. Brasfield, M.D., a neurosurgeon, on March 17, 2009, for evaluation at the request of his attorney. (R. at 386-89.) Dr. Brasfield noted that, despite Campbell's claims of anxiety with an inability to continue to drive following his September 2005 motor vehicle accident, he had, in fact, driven himself to the appointment, approximately an hour and a half from his home, despite being accompanied by his wife, who could have driven. (R. at 386.) Campbell reported taking Lortab, Soma, Lexapro and amitriptyline. (R. at 386.) He reported very limited daily activities, but Dr. Brasfield stated that these limitations were self-imposed. (R. at 386.) Campbell did not appear to be in distress, both knee reflexes were normal, but ankle reflexes were suppressed. (R. at 386.) Straight leg raise testing was negative bilaterally in the sitting position. (R. at 386.) There was no evidence of atrophy in the legs and no edema. (R. at 386-87.) There was negative reflex sympathetic dystrophy, ("RSD"),[10] and Campbell's gait was normal, but he could not stand on his toes. (R. at 387.) He had normal lordosis of the lumbar spine, no spasm, a level pelvis and no scoliosis. (R. at 387.) On range of motion, Campbell extended five degrees and forward flexed 80 degrees with normal lumbar segmentation. (R. at 387.) Lumbar

[10] Reflex sympathetic dystrophy syndrome is a rare disorder of the sympathetic nervous system that is characterized by chronic, severe pain. *See* WEBMD, http://www.webmd.com/brain/reflex-sympathetic-dystrophy-syndromee (last visited Aug. 18, 2014).

Spurling test[11] was negative, as were lumbar facet test and fabere sign.[12] (R. at 387.)

After reviewing extensive medical records of Campbell's, Dr. Brasfield did not recommend any further treatment of the lumbar strain, as the records clearly identified no lumbar fracture. (R. at 387.) Dr. Brasfield noted that Campbell remained neurologically intact regarding the lumbar spine. (R. at 387.) He further noted that Campbell's minimal daily activities, in the face of absent neurological deficit, did not have a medical basis. (R. at 387.) He opined that, if Campbell engaged in a disciplined walking program, his lumbar pain would be improved, and he should return to normal activities very quickly. (R. at 387.) He further opined that, with regard to his lumbar strain, there were no historical or physical findings that should prevent Campbell from working full-duty employment. (R. at 387.) In reference to Campbell's anxiety, Dr. Brasfield did not place any restrictions on him, citing Campbell's ability to drive to his appointment, which was one and one-half hours from his home, despite his claims of inability to drive since the accident. (R. at 387.) Dr. Brasfield opined that Campbell had reached maximum medical improvement regarding his accident. (R. at 387.) He did not believe his diverticulitis was the cause of his back pain or symptoms, and it was not within the probable medical likelihood that the diverticulitis was caused by the accident. (R. at 387.) Dr. Brasfield reported that there was every indication that

[11] Spurling test is an evaluation for cervical nerve root impingement. *See* MEDILEXICON, http://www.medilexicon.com/medicaldictionary.php?t=90833 (last visited Aug. 18, 2014).

[12] Patrick's test is performed with the patient supine. The thigh and knee are flexed, and the external malleolus is placed over the patella of the opposite leg; the knee is depressed, and if pain is produced thereby, arthritis of the hip is indicated. Patrick calls this test fabere sign, from the initial letters of the movements that are necessary to elicit it, namely, flexion, abduction, external rotation, extension. *See* DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, ("Dorland's"), 1688 (27th ed. 1988).

Campbell had made excellent recovery from his splenic injury, fractured ribs and lung contusion, and there was no evidence that he could find to suggest that Campbell's ongoing complaints were related to the accident. (R. at 387-88.)

Julie Jennings, Ph.D., a state agency psychologist, completed a Psychiatric Review Technique, ("PRT"), on July 13, 2009, finding that Campbell was mildly restricted in his activities of daily living, experienced mild difficulties in maintaining social functioning and in maintaining concentration, persistence or pace and had experienced no episodes of decompensation of extended duration. (R. at 66-68.) Jennings deemed Campbell's subjective allegations partially credible. (R. at 68.) She concluded that his impairments did not meet or equal the criteria for a listed impairment. (R. at 67.)

Dr. Robert McGuffin, M.D., a state agency physician, completed a Physical Residual Functional Capacity Assessment on July 13, 2009, finding that Campbell could occasionally lift and/or carry items weighing up to 20 pounds and frequently lift and/or carry items weighing up to 10 pounds. (R. at 68-71.) Dr. McGuffin found that he could stand and/or walk for a total of about six hours in an eight-hour workday and could sit for a total of about six hours in an eight-hour workday. (R. at 68.) Dr. McGuffin found that Campbell could frequently balance, stoop, kneel and crouch, occasionally climb ramps and stairs and crawl, but never climb ladders, ropes or scaffolds. (R. at 69.) He opined that Campbell should avoid concentrated exposure to hazards such as machinery and heights. (R. at 69.) Dr. McGuffin concluded that Campbell's back, leg, rib and other joint pain did not limit his ability to stand, walk and move about within normal limits. (R. at 71.)

He further concluded that his condition did not affect his ability to understand, remember, cooperate with others or perform his normal daily activities. (R. at 71.)

On September 17, 2009, Campbell presented to Norton Community Hospital, stating he had been out of his medications for a week and had been in pain for four days. (R. at 489-502.) He reported that he could not get an appointment with Dr. Kanwal until September 28. (R. at 489.) He was informed that he would need to see Dr. Kanwal or seek the services of a chronic pain clinic regarding this matter, as the Emergency Department could not dispense narcotics to individuals who have a physician managing their chronic pain. (R. at 489-90.) He was diagnosed with chronic back pain and received a Toradol injection. (R. at 490.) Campbell was released home in stable condition. (R. at 489.)

Richard J. Milan, Jr., Ph.D., a state agency psychologist, completed a PRT on March 22, 2010, finding that Campbell was only mildly restricted in activities of daily living, experienced mild difficulties maintaining social functioning and in maintaining concentration, persistence or pace and had experienced no episodes of decompensation of extended duration. (R. at 77-78.) Milan noted that, while the medical evidence of record indicated documentation for anxiety and depression, it failed to provide support that these constituted severe impairments. (R. at 77.) Therefore, Milan concluded that Campbell retained the mental capacity to perform all levels of work. (R. at 77.)

Dr. Brian Strain, M.D., a state agency physician, completed a Physical Residual Functional Capacity Assessment on March 22, 2010, finding that Campbell could occasionally lift and/or carry items weighing up to 20 pounds,

frequently lift and/or carry items weighing up to 10 pounds, stand and/or walk a total of about six hours in an eight-hour workday and sit a total of about six hours in an eight-hour workday. (R. at 78-82.) Dr. Strain found that Campbell could frequently balance, stoop, kneel and crouch, occasionally climb ramps and stairs and crawl, but never climb ladders, ropes or scaffolds. (R. at 79.) He found that Campbell should avoid concentrated exposure to hazards such as machinery and heights. (R. at 80.)

Campbell presented to Norton Community Hospital on December 16, 2010, with complaints of low back pain with left leg numbness and pain in the left side. (R. at 474-88) A chest x-ray showed no new focal consolidation when compared to a chest x-ray dated September 30, 2008. (R. at 487.) A lumbar spine x-ray showed only mild degenerative changes, and the spinal alignment was grossly maintained. (R. at 488.) There was no gross evidence of compression deformity. (R. at 488.) Campbell was given prescriptions for Lortab and Flexeril, and he was instructed to follow up with an orthopaedist. (R. at 478, 484.)

Campbell presented to Norton Community Hospital on April 4, 2011, with complaints of low back pain radiating down the right leg, after falling on April 2, 2011, when his right leg gave way. (R. at 454-73.) He received Toradol and Valium injections, as well as diazepam, ketorolac and hydrocodone. (R. at 459, 462.) A urine screen was positive for benzodiazepines and marijuana. (R. at 461, 469.) A CT scan of the abdomen and pelvis showed diverticula in the colon without evidence of acute diverticulitis, a small midline hernia with protrusion of fat with stranding, bladder wall thickening and a left basilar pulmonary nodule. (R. at 470, 472.) He was discharged with Norco. (R. at 458.)

Campbell saw B. Wayne Lanthorn, Ph.D., a licensed clinical psychologist, on May 17, 2011, at the request of his attorney. (R. at 503-14.) Lanthorn noted that Campbell came to the appointment unaccompanied. (R. at 504.) He was fully oriented. (R. at 504.) Lanthorn noted Rubenstein's diagnoses of adjustment disorder with mixed anxiety and depressed mood, as well as some symptoms of PTSD. (R. at 506-07.) Campbell reported that he basically does "nothing," watches the dog and sometimes visits with his parents. (R. at 507.) He also reported occasionally grocery shopping and attending church. (R. at 507.) He stated that he watched television, but rarely read. (R. at 507.) Lanthorn noted that Campbell showed no signs of ongoing psychotic processes or evidence of delusional thinking. (R. at 508.) Campbell stated that, prior to the motor vehicle accident, he had no significant psychological problems. (R. at 508.) However, since that time, he had significant difficulties, noting worsening depression despite being placed on an anti-depressant. (R. at 508.) Campbell reported that he did not believe the medication was helping. (R. at 508.) He reported frequent irritability and highly variable energy levels, but generally poor. (R. at 508.) He admitted occasional suicidal ideation, but denied a plan or intent. (R. at 508.) He indicated that his memory functions were adequate, but concentration was variable, but generally poor and that his mind wandered. (R. at 508.) Campbell reported difficulty initiating and completing tasks successfully. (R. at 508.) He also reported significant initial sleep disruption, and he estimated sleeping a total of three to four hours nightly. (R. at 508.) Campbell stated that he was often anxious and nervous at times, contributing to his irritability. (R. at 508.) He described feeling shaky, restless and easily agitated. (R. at 508.) Campbell reported being overwhelmed by relatively minor stressors. (R. at 508.) Campbell reported having

severe panic attacks in the past, but stated it had been approximately a year since he had experienced one. (R. at 509.)

Lanthorn administered the Wechsler Adult Intelligence Scale – Fourth Edition, ("WAIS-IV"), on which Campbell achieved a full-scale IQ score of 77, placing him in the borderline range. (R. at 509.) He earned a verbal IQ score of 72, also placing him in the borderline range. (R. at 509.) Lanthorn reported that Campbell gave a good effort on the test, and he felt that the results were valid and accurately reflected Campbell's then-current degree of intellectual functioning. (R. at 509.) Lanthorn also administered the Minnesota Multiphasic Personality Inventory – 2 ("MMPI-2"), which indicated that Campbell was experiencing serious psychopathology that included confused thinking, difficulties in logic and concentration and impaired judgment. (R. at 510-12.) Tests further indicated that Campbell was experiencing severe emotional distress and was having concentration and attention difficulties, memory difficulties and, quite likely, poor judgment. (R. at 512.)

Lanthorn diagnosed major depressive disorder, single episode, severe; anxiety disorder with both panic attacks and generalized anxiety due to chronic physical conditions, pain, etc.; pain disorder associated with both psychological factors and general medical conditions, chronic; and borderline intellectual functioning. (R. at 512-13.) He placed Campbell's then-current GAF score at 50.[13] (R. at 513.) He concluded that his psychopathology was serious and fully credible, and he rated Campbell's psychological prognosis as "guarded." (R. at 513.) Lanthorn opined that Campbell needed both psychiatric and

[13] A GAF score of 41 to 50 indicates that the individual has serious symptoms or serious impairments in social, occupational or school functioning. *See* DSM-IV at 32.

psychotherapeutic intervention, which he should consider obtaining as soon as possible. (R. at 513.) He opined that Campbell's psychopathology represented an incapacitating degree of ability to function in gainful employment, and that he appeared to have these problems since at least 2006 following his accident. (R. at 514.)

Lanthorn also completed a mental assessment the same day, finding that Campbell had a good ability to understand, remember and carry out simple job instructions and to maintain personal appearance. (R. at 515-17.) He found that Campbell had a fair ability to follow work rules, to relate to co-workers, to deal with the public, to use judgment, to interact with supervisors, to function independently, to maintain attention and concentration, to understand, remember and carry out detailed, but not complex, job instructions, to behave in an emotionally stable manner, to relate predictably in social situations and to demonstrate reliability. (R. at 515-16.) Lanthorn opined that Campbell had a poor or no ability to deal with work stresses or to understand, remember or carry out complex job instructions. (R. at 515-16.) He opined that Campbell would be absent from work more than two days monthly due to his impairments. (R. at 517.)

III. Analysis

The Commissioner uses a five-step process in evaluating SSI claims. *See* 20 C.F.R. § 416.920 (2013); *see also Heckler v. Campbell*, 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. § 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. § 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. § 1382c(a)(3)(A)-(B) (West 2003 & Supp. 2014); *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).

Campbell argues that the ALJ erred by making incomplete findings at step three of the sequential evaluation process. (Plaintiff's Memorandum In Support Of His Motion For Summary Judgment, ("Plaintiff's Brief"), at 6.) Campbell further argues that the ALJ erred by improperly determining his residual functional capacity by giving improper weight to the opinions of Dr. Kanwal, Lanthorn and Jessee. (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 his findings and his 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. § 416.927(c), if he sufficiently explains his rationale and if the record supports his findings.

Campbell argues that the ALJ erred by making incomplete findings at step three of the sequential evaluation process in determining that he did not meet or equal the criteria of the mental listings. (Plaintiff's Brief at 6.) More specifically, Campbell argues that the ALJ erred by failing to explain his conclusion that his impairment(s) did not satisfy the "paragraph B" criteria necessary for a mental impairment to satisfy a listed mental impairment. (Plaintiff's Brief at 6.) Campbell argues that the ALJ is required to provide findings in the decision that are essential to the sequential evaluation process, and that a clear explanation of supporting evidence used to reach a conclusion is essential, because, without such,

a meaningful review of the decision is impossible. (Plaintiff's Brief at 6.) I find Campbell's argument unpersuasive.

The Social Security regulations define a "nonsevere" impairment as an impairment or combination of impairments that does not significantly limit a claimant's ability to do basic work activities. *See* 20 C.F.R. § 416.921(a) (2013). Basic work activities include walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, handling, seeing, hearing, speaking, understanding, carrying out and remembering simple instructions, use of judgment, responding appropriately to supervision, co-workers and usual work situations and dealing with changes in a routine work setting. *See* 20 C.F.R. § 416.921(b) (2013). The Fourth Circuit held in *Evans v. Heckler*, that ""[a]n impairment can be considered as 'not severe' only if it is a *slight abnormality* which has such a *minimal effect* on the individual that it would not be expected to interfere with the individual's ability to work, irrespective of age, education, or work experience."" 734 F.2d 1012, 1014 (4th Cir. 1984) (quoting *Brady v. Heckler*, 724 F.2d 914, 920 (11th Cir. 1984)) (citations omitted).

The ALJ found that, other than borderline intellectual functioning, Campbell's medically determinable mental impairments of major depressive disorder and anxiety disorder, considered singly and in combination, did not cause more than minimal limitation in his ability to perform basic mental work activities and, therefore, were not severe. (R. at 21.) Thus, the ALJ found that Campbell's anxiety and depression were not severe at step two of the sequential evaluation process, (R. at 21), and he was not required to analyze whether they met or equaled the criteria of the listings. *See Zegray v. Colvin*, 2013 WL 1566632, *8 (D. S.C.

Apr. 12, 2013) (holding that because "the ALJ found at step two that Plaintiff's alleged impairments of depression, anxiety, and alcohol and marijuana abuse were not severe impairments, she was not required to consider whether those alleged impairments equaled a Listing."); *Washington v. Astrue*, 698 F. Supp. 2d 562, 581 (D. S.C. Mar. 17, 2010) (finding that because "the ALJ did not find Plaintiff's obstructive sleep apnea to be 'severe,' there was no reason for him to assess whether it met or equaled a Listing.").

In arriving at this conclusion, the ALJ noted that Campbell was only mildly limited in his activities of daily living, mildly limited in social functioning, moderately limited in concentration, persistence or pace and had experienced no episodes of decompensation of extended duration. (R. at 21.) This finding is supported by the opinions of the state agency psychologists, both of whom opined that Campbell was mildly restricted in his activities of daily living, experienced mild difficulties in maintaining social functioning and in maintaining concentration, persistence or pace and had experienced no episodes of decompensation of extended duration. (R. at 66-68, 77-78.) The ALJ also noted that Campbell had been assessed as having normal mental status on all examinations by treating physicians, had not received inpatient mental health treatment and had functioned adequately in the home he shared with his wife. (R. at 21.) Lastly, there is evidence in the record that medications helped lessen Campbell's symptoms of depression and anxiety. "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).

Campbell also argues that the ALJ erred by improperly determining his residual functional capacity by according improper weight to the opinions of his treating and examining sources, including Dr. Kanwal, psychologist Lanthorn and chiropractor Jessee. (Plaintiff's Brief at 7-10.) More specifically, Campbell argues that the ALJ erred by rejecting the opinions of Dr. Kanwal and psychologist Lanthorn and by rejecting chiropractor Jessee's opinion regarding his limitations as set forth in his residual functional capacity assessment, including that Campbell would have an excessive rate of absenteeism. (Plaintiff's Brief at 9.)

I first note that the issue of a claimant's residual functional capacity is reserved solely to the ALJ. *See* 20 C.F.R. § 416.927(d). The ALJ must consider objective medical facts and the opinions and diagnoses of both treating and examining medical professionals, which constitute a major part of the proof of disability cases. *See McLain*, 715 F.2d at 869. 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. § 416.927(c)(2). 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)). 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. Furthermore, while an ALJ may not reject medical evidence for no reason or for the wrong reason, *see King*, 615 F.2d at 1020, 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. § 416.927(c), if he sufficiently explains his rationale and if the record supports his findings.

In a September 2, 2010, letter, Dr. Kanwal, Campbell's treating physician, opined that Campbell was permanently and totally disabled from any gainful employment due to residuals from the September 2005 motor vehicle accident. (R. at 422.) In a physical assessment dated March 10, 2011, Dr. Kanwal opined that Campbell's limitations were such that he could not perform any exertional level of work. (R. at 451-53.) He also opined that Campbell would be absent from work more than two days monthly due to his impairments. (R. at 453.) Dr. Kanwal noted that he based these restrictions on Campbell's chronic back pain and disc disease, multiple rib fractures with pain, COPD, anxiety and depression. (R. at 451, 453.) The ALJ gave little weight to these opinions because he found that they were inconsistent with the other evidence of record. (R. at 24.) I find that substantial evidence supports the ALJ's weighing of the evidence. First, Dr. Kanwal's opinions of disability are inconsistent with the diagnostic evidence of record, including MRIs of the lumbar spine showing no disc herniation and no spinal canal or neural foraminal narrowing at any level. (R. at 546-47.) A May 2007 x-ray of the lumbar spine showed degenerative disc disease / spondylosis and possible disc displacement at the L4 and L5 vertebral levels, but Jessee suggested MRI confirmation. (R. at 417.) November 13, 2009, x-rays of the lumbar spine and pelvis showed lumbar spondylosis with disc displacement, biomechanical alterations of the lumbar spine and pelvic unleveling. (R. at 418.) A December 16, 2010, x-ray of the lumbar spine showed only mild degenerative changes, and the spinal alignment was grossly maintained. (R. at 488.) There was no evidence of compression deformity. (R. at 488.) In addition to the diagnostic evidence, the

clinical evidence also supports the ALJ's decision to give little weight to Dr. Kanwal's opinion evidence. For instance, when Campbell saw Dr. Brasfield, a neurosurgeon, in March 2009, he had driven himself to the appointment, which was an hour and a half from his home, both knee reflexes were normal, straight leg raise testing was negative bilaterally in a sitting position, there was no evidence of atrophy in the legs and no edema, there was negative RSD, and Campbell's gait was normal. (R. at 386-88.) Inspection of the spine revealed normal lordosis, no spasm, a level pelvis and no scoliosis. (R. at 387.) Campbell could extend five degrees and forward flex 80 degrees with normal lumbar segmentation. (R. at 387.) Lumbar Spurling test was negative, as were lumbar facet test and fabere sign. (R. at 387.) Dr. Brasfield noted that Campbell had remained neurologically intact regarding the lumbar spine. (R. at 387.)

I also find that the AJL's decision to accord little weight to Lanthorn's opinion that Campbell suffered from disabling mental impairments is supported by substantial evidence in the record. For instance, as the ALJ noted in his decision, such opinion is contrary to Campbell's complete lack of mental health treatment history prior to filing his SSI claim. The only mental health treatment Campbell has undergone is that from Rubenstein, which his attorney arranged for him. Campbell admits that he never sought any prior mental health treatment, and he has never been hospitalized as a result of his psychological impairments. Additionally, despite allegations of a practical inability to drive due to anxiety following the September 2005 motor vehicle accident, Dr. Brasfield noted, in March 2009, that Campbell had driven himself to the appointment, an approximate one and a half hour drive one way, even though his wife could have driven. Campbell expressed no difficulties due to his having driven to the appointment at

that time. Finally, both Campbell and his wife have reported on multiple occasions that anti-depressant medications have helped his symptoms. For instance, in June 2006, both Campbell and his wife informed Rubenstein that he was less irritable after Dr. Kanwal had prescribed Lexapro. (R. at 221.) Later that month, Campbell's wife again stated that he was improving. (R. at 223.) By July 2006, both Campbell and his wife reported noticeable improvement with Lexapro, noting less brooding, less irritability and a bit less anxiety when driving. (R. at 224.) Also, at his hearing, he testified that his medications helped, as long as he stayed away from crowds. (R. at 54.) *See Gross*, 785 F.2d at 1166 ("If a symptom can be reasonably controlled by medication or treatment, it is not disabling."). Finally, Lanthorn's opinion that Campbell suffers from disabling mental impairments is inconsistent with the findings of the state agency psychologists, set out above.

The ALJ stated that he was giving considerable weight to chiropractor Jessee's opinion that Campbell was capable of performing a limited range of light work because it was consistent with the preponderance of the evidence including Campbell's routine, conservative treatment and unremarkable diagnostic and clinical test results. (R. at 25-26.) Campbell argues that the ALJ erred, however, by failing to give appropriate weight to Jesse's opinion regarding his limitations as set forth in his residual functional capacity assessment, including that Campbell would have an excessive rate of absenteeism. I find that the ALJ's weighing of the evidence is supported by substantial evidence for the same reasons as stated above.

Finally, I find that substantial evidence supports the ALJ's decision to give significant weight to Dr. Brasfield's opinion that Campbell had recovered from the injuries sustained in the 2005 motor vehicle accident and was capable of returning

to work because it was consistent with the objective medical testing showing that Campbell had no neurological deficits. (R. at 25, 386-88, 546, 549). As the ALJ stated, Dr. Brasfield's opinion also was supported by the results of his physical examination of Campbell, which revealed that he had a normal gait, no atrophy of the legs, bilateral negative straight leg raise testing, and the ability to forward flex to 80 degrees with normal lumbar segmentation. (R. at 386-88.) Dr. Brasfield's opinion is further supported by the findings of the state agency physicians, who opined that Campbell could perform a significant range of light work that did not require him to climb ladders, ropes or scaffolds and that did not require concentrated exposure to hazards such as machinery and heights. (R. at 68-71, 78-82.)

Considering all of the objective medical evidence, opinion evidence and Campbell's subjective complaints, the ALJ found that Campbell had the residual functional capacity to perform unskilled, sedentary work that required no more than occasional postural movements, no climbing of ladders, ropes or scaffolds and no exposure to vibration, respiratory irritants, hazards or unprotected heights. (R. at 22-26.) As the Commissioner notes in her Brief, this residual functional capacity finding was generous in light of Campbell's fairly unremarkable diagnostic and clinical test results, and it gave considerable benefit of the doubt to Campbell's subjective complaints. Nonetheless, even with the ALJ's very restrictive residual functional capacity finding, the vocational expert testified that Campbell could perform jobs existing in significant numbers in the national economy. Such testimony constitutes substantial evidence that Campbell was not disabled.

Based on the above-cited evidence, I find that substantial evidence supports the ALJ's residual functional capacity finding as to both Campbell's mental and physical impairments. Therefore, I find that substantial evidence supports the ALJ's finding that Campbell is not disabled and not entitled to 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 weighing of the medical and psychological evidence;

2. Substantial evidence exists in the record to support the ALJ's finding with regard to Campbell's physical and mental residual functional capacities; and

3. Substantial evidence exists in the record to support the ALJ's finding that Campbell was not disabled under the Act and was not entitled to SSI benefits.

RECOMMENDED DISPOSITION

The undersigned recommends that the court deny Campbell'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. 2014):

> 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 the plaintiff and to all counsel of record at this time.

DATED: August 20, 2014.

/s/ *Pamela Meade Sargent*
UNITED STATES MAGISTRATE JUDGE