

“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 Culbertson protectively filed an application for DIB on January 19, 2010, (Record, (“R.”), at 222-23, 111, 139), alleging disability as of March 7, 2003, due to nerves, depression, anxiety, tachycardia and post-traumatic stress disorder. (R. at 139, 244.)¹ The claim was denied initially and on reconsideration. (R. at 139-47, 149-53, 154-56, 157-61, 162, 163-65.) Culbertson then requested a hearing before an administrative law judge, (“ALJ”), (R. at 166-68.) A video conference hearing was held on May 18, 2012, at which, Culbertson was not represented by counsel. (R. at 108-35.)

By decision dated June 1, 2012, the ALJ denied Culbertson’s claim. (R. at 87-97.) The ALJ found that Culbertson met the nondisability insured status requirements of the Act for DIB purposes through December 31, 2008.² (R. at 90.) The ALJ also found that Culbertson had not engaged in substantial gainful activity from March 7, 2003, to December 31, 2008. (R. at 90.) The ALJ found that the medical evidence established that, through the date last insured, Culbertson

¹ Culbertson filed a prior application on June 5, 2007, which apparently also was denied. (R. at 211-13, 239-42.)

² Therefore, Culbertson must show that she became disabled between March 7, 2003, the alleged onset date, and December 31, 2008, the date last insured, in order to be entitled to DIB benefits.

suffered from a combination of severe impairments, namely carpal tunnel syndrome, gastroesophageal reflux disease, obesity, migraine headaches and restless leg syndrome, but he found that Culbertson 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 90-92.) The ALJ also found that, through the date last insured, Culbertson had the residual functional capacity to perform the full range of light work.³ (R. at 93-95.) The ALJ found that, through her date last insured, Culbertson was unable to perform any past relevant work. (R. at 96.) Based on Culbertson's age, education, work history and residual functional capacity and the Medical-Vocational Guidelines, ("the Grids"), 20 C.F.R. Part 404, Subpt. P, App. 2, the ALJ found that Culbertson was not under a disability as defined under the Act and was not eligible for benefits. (R. at 96-97.) *See* 20 C.F.R. § 404.1520(g) (2013).

After the ALJ issued his decision, Culbertson pursued her administrative appeals, (R. at 79), but the Appeals Council denied her request for review. (R. at 1-3.) Culbertson 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 (2013). The case is before this court on Culbertson's motion for summary judgment filed December 3, 2013, and the Commissioner's motion for summary judgment filed February 4, 2014. Neither party has requested oral argument.

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, she also can perform sedentary work. *See* 20 C.F.R. § 404.1567(b)(2013).

II. Facts

Culbertson was born in 1955, (R. at 96, 211), which classified her as a “younger person” under 20 C.F.R. § 404.1563(c) on the alleged onset date, but as a “person closely approaching advanced age” under 20 C.F.R. § 404.1563(d) by her date last insured. Culbertson has a high school education and past relevant work experience as a nursing assistant. (R. at 117, 249.)

At her hearing, Culbertson testified that she had worked as a nurse’s aide from 1991 to 2003. (R. at 117.) Culbertson said that she was no longer able to work as a nurse’s aide because of problems with her back and legs. (R. at 117.) Culbertson testified that her legs would go numb, and she had shooting pain down her legs. (R. at 117.) Culbertson admitted that she continued to perform work similar to her job as a nurse’s aide during the relevant period for her relatives. (R. at 118.) Culbertson testified that she did not have any problem with her back prior to her last insured date, December 31, 2008. (R. at 118.)

Culbertson testified that she also had carpal tunnel syndrome, which caused problems lifting and picking up items with her hands. (R. at 119.) Culbertson said that she suffered from carpal tunnel syndrome while she was still working. (R. at 119.) Culbertson said that her bladder problems had occurred over the previous two years. (R. at 119-20.) Culbertson also testified that she had suffered from migraine headaches, irritable bowel syndrome, restless leg syndrome, depression and anxiety since before she quit working. (R. at 120-23.) Culbertson said that she suffered from crying spells, difficulty sleeping and panic attacks prior to December 31, 2008. (R. at 123-25.) Culbertson testified that, during a panic attack, her heart

would start racing and she would feel hot and nauseous. (R. at 125.) She said she would start crying and shaking. (R. at 125.)

Culbertson testified that she got along well with people. (R. at 126.) She said that it was difficult to do housework, but that she did laundry, mopping and sweeping on a regular basis. (R. at 126.) Culbertson admitted that she was able to do more prior to December 31, 2008. (R. at 127.) Culbertson testified that she had been sexually molested as a child and that a granddaughter was sexually molested in 2009. (R. at 127-28.)

Vocational expert, AnnMarie E. Cash, testified by telephone at Culbertson's hearing. (R. at 129-33.) Cash classified Culbertson's work as a certified nursing assistant as medium⁴ and semi-skilled. (R. at 130.) Cash was asked to consider a hypothetical individual of Culbertson's age, education and work experience who would be limited to occasionally lifting and carrying items weighing up to 50 pounds, frequently lifting and carrying items weighing up to 25 pounds, who could stand and walk about six hours and sit for about six hours in an eight-hour workday, could push and pull consistent with her lifting limitations, could never climb ladders, ropes or scaffolds, could frequently climb ramps and stairs, stoop, kneel, crouch and crawl and should avoid concentrated exposure to operational control of moving machinery and unprotected heights. (R. at 130-31.) Cash also was asked to assume that this individual would be limited to simple, routine and repetitive tasks, less than occasional interaction with the public, but occasional

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, she also can do sedentary and light work. *See* 20 C.F.R. § 404.1567(c) (2013).

interaction with co-workers and supervisors. (R. at 131.) Cash stated that such an individual could not work as a certified nursing assistant, but could perform medium, unskilled work such as work as a food prep worker, a dishwasher or a stock clerk. (R. at 131-32.)

Cash stated that if the same individual was limited to occasionally lifting and carrying items weighing up to 20 pounds and frequently lifting and carrying item weighing up to 10 pounds and could only occasionally climb ramps and stairs, stoop, kneel, crouch and crawl, the individual could work as a food prep worker, a dishwasher, a stock clerk or an order filler at the light, unskilled level of exertion. (R. at 132.) Cash testified that, if the individual was off task about five times a day and had to take unscheduled bathroom breaks, there would be no work that she could perform. (R. at 133.)

In rendering his decision, the ALJ reviewed medical records from Dr. I. N. Kutty, M.D.; Suzanne Saylor, F.N.P.; Dr. Edwin A. Griffin, M.D.; Dr. Bendik Clark, M.D.; Dr. Larry T. Wilson, M.D.; Holston Medical Group Urgent Care Clinic; Holston Valley Medical Center; Dr. Allen Chan, M.D.; state agency psychologists Joseph I. Leizer, Ph.D., E. Hugh Tenison, Ph.D., and Louis Perrott, Ph.D.; state agency physicians, Dr. Joseph Duckwall, M.D., Dr. John Sadler, M.D., and R. Joyce Goldsmith, M.D.; Dr. Sitaram G. Kadekar, M.D.; Dr. Jerry F. London, M.D.; Dr. Marc Mayhew, M.D.; Dr. Chadi Jarjoura; Dr. Lauren Franklin, M.D.; Janice F. Ewing, F.N.P.; Dr. Bryan Arnette, M.D.; Dr. Frederick A. Klein, M.D.; Dr. Charles Payne, M.D.; Dr. C. Glenn Trent, Jr., M.D.; Dr. Octavio J. Pinell, M.D.; Dr. Mark L. Withrow, M.D.; Dr. Sheldon H. Fisher, D.O., and Rona C. Addington, A.N.P.. Culbertson's attorney submitted additional medical reports

from Dr. Nerissa Licup, M.D., and Dr. Gregory Corradino, M.D., to the Appeals Council.⁵

Culbertson treated with Dr. I.N. Kutty, M.D., a psychiatrist, from August 1996 through January 2003. (R. at 358-84.) On August 1, 1996, Dr. Kutty noted Culbertson's chief complaint as "can't cope" and complaining of relationship and other problems with her 18-year-old daughter. (R. at 372.) Culbertson stated that she had attempted to commit suicide two years ago, but her daughter had taken the gun from her. (R. at 372.) Culbertson said that she was taken to the hospital, but she refused to be admitted. (R. at 372.) She was prescribed trazodone. (R. at 372.) She stated that she had not done well in two years. (R. at 372.) Culbertson complained of crying spells, inability to be alone and decreased energy. (R. at 372.) She also said that her appetite had decreased, and she had lost six pounds recently. (R. at 372.)

Culbertson said that being at work helped her symptoms. (R. at 372.) Culbertson said she suffered from flashbacks of sexual abuse as a child. (R. at 371.) Culbertson said she suffered from depression, anxiety and panic attacks as a child. (R. at 371.) She denied any recent suicide attempts. (R. at 371.) Dr. Kutty stated that Culbertson was alert, anxious and depressed with no psychosis and low self-esteem. (R. at 370.) Dr. Kutty found Culbertson to be emotionally needy. (R. at 370.) Dr. Kutty diagnosed major depression, recurrent, with moderate

⁵ Since the Appeals Council considered and incorporated this additional evidence into the record in reaching its decision, (R. at 1-3), this court also must take this evidence into account when determining whether substantial evidence supports the ALJ's findings. *See Wilkins v. Sec'y of Dep't of Health & Human Servs.*, 953 F.2d 93, 96 (4th Cir. 1991).

symptoms, anxiety disorder, not otherwise specified, and post-traumatic stress disorder. (R. at 370.) On October 27, 1999, Dr. Kutty noted that Culbertson was doing well with her depression well-controlled. (R. at 369.)

Dr. Kutty's March 1, 2000, report states that Culbertson complained of being addicted to Ativan and that she could not sleep without it. (R. at 384.) Culbertson said that she was not depressed, but she experienced "transient dysthymia" now and then. (R. at 384.) Dr. Kutty noted no abnormality in Culbertson's appearance, affect, mood, sensorium, memory, thought content, thought process or judgment. (R. at 384.) His note, some of which is illegible, does not appear to list a diagnosis, but it does note that Culbertson should continue taking Zoloft and increase her dosage of trazodone. (R. at 384.)

On May 24, 2000, Dr. Kutty noted that there was no change in Culbertson's health. (R. at 383.) He noted that Culbertson said that she was sleeping better on Ambien than on trazodone. (R. at 383.) She also reported that Zoloft had "helped," and she was "less depressed." (R. at 383.) She did report getting anxious at times. (R. at 383.) Culbertson also said that she was able to handle work. (R. at 383.) Dr. Kutty noted good response to her medication and that her symptoms were under good control. (R. at 383.) Dr. Kutty prescribed Zoloft and Ambien. (R. at 383.) On August 16, 2000, Culbertson complained of "some crying spells" when she saw people suffering; she said she identified with them. (R. at 382.) Culbertson denied suffering from any panic attacks, and she stated that she was able to do her job. (R. at 382.) Dr. Kutty noted that Culbertson's mood was depressed. (R. at 382.) He stated that she was tolerating her medications and that her symptoms were under good control. (R. at 382.) Dr. Kutty increased the dosage of Culbertson's Zoloft

prescription and continued her prescription for Ambien. (R. at 382.)

On January 31, 2001, Culbertson complained of being depressed despite taking Zoloft; she said she had crying spells and was not sleeping well. (R. at 381.) Dr. Kutty noted that Culbertson's affect was blunted, and her mood was anxious and depressed. (R. at 381.) Dr. Kutty again increased Culbertson's dosage of Zoloft and prescribed Sonata. (R. at 381.) On April 25, 2001, Culbertson reported that she was sleeping well on Sonata. (R. at 380.) She also said that the Zoloft had helped, and she was less depressed. (R. at 380.) Culbertson said that her work was going well, and she was enjoying life. (R. at 380.) Dr. Kutty noted good control of Culbertson's symptoms and continued her medications as before. (R. at 380.) On August 28, 2001, Culbertson told Dr. Kutty she was doing fine. (R. at 379.) She denied any crying spells. (R. at 379.) She stated that she sometimes would get depressed, but it would not last long. (R. at 379.) She stated that she was sleeping well and was able to do her job. (R. at 379.) Despite noting that Culbertson's symptoms were in good control, Dr. Kutty increased the dosage on her Zoloft. (R. at 379.)

Culbertson returned to Dr. Kutty on November 20, 2001, complaining of a few panic attacks and sobbing while lying in bed. (R. at 378.) While much of this note is not legible, Dr. Kutty diagnosed post-traumatic stress disorder and prescribed psychotherapy to address it. (R. at 378.) On February 12, 2002, Culbertson complained of increased panic attacks. (R. at 377.) Culbertson complained of trouble sleeping, but Dr. Kutty noted that she was not going to bed until 1:30 a.m. and getting up at 6 a.m. (R. at 377.) Dr. Kutty recommended that she attempt to get six to eight hours of sleep a night. (R. at 377.)

On May 7, 2002, Culbertson told Dr. Kutty that she was doing great and enjoying life. (R. at 376.) Dr. Kutty noted that Culbertson's symptoms were in remission. (R. at 376.) Culbertson continued to deny any depression or panic when she returned to see Dr. Kutty on September 17, 2002. (R. at 375.) On January 2, 2003, Culbertson stated that she had been doing well, but was sad over a family illness and her best friend moving away. (R. at 374.)

Culbertson saw Suzanne Saylor, R.N., F.N.P., for a chief complaint of rectal bleeding on July 3, 2003. (R. at 534-36.) Culbertson gave a history of bright red blood in the bowl and on the tissue after every bowel movement for the previous two weeks. (R. at 534.) Culbertson complained of rectal pain after prolonged sitting or standing. (R. at 534.) She stated that sitz baths seemed to improve the pain some. (R. at 534.) Culbertson also complained of diarrhea and reflux. (R. at 534.) She gave a history of peptic ulcer disease. (R. at 534.) Saylor diagnosed Culbertson with external hemorrhoids, diarrhea secondary to irritable bowel syndrome, heartburn and epigastric pain. (R. at 536.) Saylor prescribed medication for Culbertson's hemorrhoids, reflux and diarrhea. (R. at 536.)

Culbertson saw Dr. Edward A. Griffin, M.D., on March 28, 2002, for daily headaches for the previous two to three weeks. (R. at 901.) Dr. Griffin prescribed Toradol. (R. at 901.) Culbertson returned to Dr. Griffin on April 8, 2002, to recheck her liver enzymes. (R. at 900.) Culbertson complained of daily chest pain radiating into her neck and jaw after, but not during, exercise. (R. at 900.) Dr. Griffin noted that an EKG was completely normal. (R. at 900.) Culbertson underwent a cardiac stress test on April 19, 2002, which did not show any cardiac

abnormalities, but did show that Culbertson was of less than average conditioning. (R. at 899.)

Culbertson returned to Dr. Griffin on May 30, 2002, with complaints of sore throat, congestion, cough and pain in her right ankle and foot. (R. at 898.) Dr. Griffin diagnosed viral upper respiratory illness and tendinitis in her foot. (R. at 898.) On June 17, 2002, Culbertson complained of leg twitches and neuromuscular irritability at night which caused sleep disturbance. (R. at 897.) Dr. Griffin diagnosed restless leg syndrome and chronic rhinitis, probably seasonal and allergic. (R. at 897.) Culbertson returned to Dr. Griffin on November 11, 2002, with a one-week history of head congestion, chest congestion and chills. (R. at 896.) Dr. Griffin diagnosed acute sinobronchitis. (R. at 896.)

On December 16, 2002, Culbertson saw Dr. Griffin for complaints of pain and stiffness in her hands. (R. at 895.) Dr. Griffin noted that Tinel's sign was positive in both wrists in that it produced glove distribution paresthesia in the hands. (R. at 895.) He noted that Phalen's sign was positive on the right, negative on the left and negative at the elbow. (R. at 895.) Dr. Griffin stated that Culbertson likely suffered from carpal tunnel syndrome. (R. at 895.) Dr. Griffin also diagnosed depression, although there was no mention of depressive symptoms in this note. (R. at 895.)

Culbertson returned to Dr. Griffin on June 5, 2003, with complaints of suprapubic pain, dysuria, hesitancy, urgency and a fever of 103 with chills and nausea. (R. at 894.) Dr. Griffin diagnosed an acute kidney infection and prescribed Levaquin. (R. at 894.) He also noted that Dr. Kutty was no longer covered by

Culbertson's insurance, so he would start writing prescriptions for her Zoloft. (R. at 894.) On June 30, 2003, Culbertson returned with complaints of rectal bleeding with some nausea for the previous two weeks. (R. at 893.) She also complained of pervasive and long-term diarrhea. (R. at 893.) Dr. Griffin's exam showed minimal right and left lower quadrant tenderness. (R. at 893.) Dr. Griffin referred Culbertson to a gastroenterologist. (R. at 893.)

On January 12, 2004, Culbertson saw Dr. Griffin for complaints of "restless leg." (R. at 892.) On this occasion, Culbertson denied any diarrhea, increasing anxiety or headaches. (R. at 892.) Dr. Griffin stated that neurologic exam of lower extremities was normal. (R. at 892.) Dr. Griffin diagnosed possible restless leg syndrome, which could be caused by taking Zoloft. (R. at 892.) Dr. Griffin decreased Culbertson's Zoloft dosage. (R. at 892.) Dr. Griffin saw Culbertson again on February 23, 2004, for follow-up for hyperlipidemia. (R. at 891.) Dr. Griffin noted that Culbertson's lipid panel test results were worse on Zocor. (R. at 891.) Dr. Griffin encouraged diet modifications and increased exercise. (R. at 891.)

On June 18, 2004, Culbertson saw Dr. Griffin for complaints of lower back, lower abdominal and suprapubic pain with a sense of dysuria, frequency and urgency. (R. at 890.) Culbertson said that her back pain was relieved by urination and bowel movement. (R. at 890.) Culbertson gave a history of long-standing irritable colon with predominant diarrhea. (R. at 890.) Dr. Griffin ordered a urinalysis to determine if Culbertson had a urinary tract infection. (R. at 890.) He stated that, if this was negative, he would recommend a sigmoidoscopy to determine if she suffered from diverticulosis. (R. at 890.) Dr. Griffin noted that the urine specimen was cloudy, and he prescribed Cipro. (R. at 890.)

Culbertson returned to Dr. Griffin on November 18, 2004, for complaints of dizziness. (R. at 889.) Culbertson said she had been seen in the emergency room on November 14 and prescribed meclizine and Ativan. (R. at 889.) Culbertson saw Dr. Griffin on January 25, 2005, complaining of a sore throat and involuntary leg movements at night. (R. at 888.) Dr. Griffin diagnosed a viral upper respiratory infection and restless leg syndrome. (R. at 888.) Dr. Griffin prescribed cough medication and Sinemet for restless leg syndrome. (R. at 888.) Culbertson returned to Dr. Griffin on April 20, 2005, with a four- to five-day history of low-grade fever and sore throat. (R. at 887.) Dr. Griffin diagnosed viral upper respiratory infection and prescribed cough medicine. (R. at 887.)

Culbertson saw Dr. Larry T. Wilson, M.D., with Holston Medical Group (“HMG”) – Weber City, for a new patient evaluation, physical and pelvic examination on September 7, 2005. (R. at 387-88.) Dr. Wilson noted that Culbertson’s musculoskeletal examination showed grossly normal ranges of motion, strength and tone without weakness, joint pain, cramps, stiffness, swellings or redness. (R. at 388.) Dr. Wilson noted that Culbertson was “oriented x3.” (R. at 388.) He also stated that Culbertson’s affect and demeanor were appropriate with normal psychomotor function and no homicidal or suicidal ideations. (R. at 388.) Dr. Wilson diagnosed Culbertson as suffering from high cholesterol and triglycerides, carpal tunnel syndrome, restless leg syndrome and depression. (R. at 388.) Dr. Wilson added a prescription for bupropion to address Culbertson’s depression and changed her medicine for her restless leg syndrome to Requip. (R. at 388.) Culbertson saw Dr. Wilson again on September 15, 2005, for a medication follow-up. (R. at 389-90.) Dr. Wilson’s findings were essentially the same as the last visit, but he changed Culbertson’s cholesterol medicines to discontinue Zocor

and Lopid and begin Vytorin, restarted her on Tofranil to address her depression and discontinued Requip. (R. at 390.)

Culbertson returned to see Dr. Wilson on December 15, 2005, complaining of low blood pressure and her pulse racing. (R. at 392-93.) Dr. Wilson noted regular heart rate and rhythm. (R. at 393.) Dr. Wilson noted that Culbertson was ambulatory with a steady gait, free of acute injury, able to move all extremities with full range of motion, denied pain with movement and had no edema of her extremities. (R. at 393.) Dr. Wilson discontinued Culbertson's prescriptions for Tofranil and Bupropion and substituted Effexor and Rozarem. (R. at 393.) Culbertson returned to HMG on February 10, 2006, complaining of panic attacks. (R. at 394-95.) Dr. James McCoy, M.D., noted that Culbertson had discontinued Effexor because it made her heart race. (R. at 394.) Dr. McCoy discontinued Culbertson's prescription for Effexor. (R. at 395.)

On March 6, 2006, Culbertson saw Linda G. Gilliam, L.P.N., and Dr. Bendik Clark, M.D., with HMG, with complaints of chest pain radiating into her left jaw and numbness in the left side of her face and lips and running down her left leg. (R. at 396-98.) Culbertson was started on oxygen, given a dose of metoprolol tartrate to address her high blood pressure, and her husband was called to take her to the emergency room. (R. at 396.) Culbertson's blood pressure was 140/92, and her heart rate was 111 beats per minute. (R. at 396.) The office note stated that Culbertson gave a remote history of panic attacks. (R. at 397.) The note also stated that Culbertson had a negative cardiac workup at the emergency room. (R. at 397.) Dr. Bendik assessed Culbertson as suffering from anxiety and noted to consider increasing her dosage of Zoloft. (R. at 397.) Dr. Bendik ordered an EKG

and also prescribed metoprolol tartrate, diazepam and Lunesta. (R. at 397-98.)

Culbertson presented to the Holston Valley Medical Center Emergency Department on March 6, 2006, complaining of facial numbness and vertigo for the previous three days or so. (R. at 437-38.) She also complained of left-sided chest pain that had been sharp in nature. (R. at 437.) Culbertson's EKG showed no evidence of any acute changes. (R. at 437.) Also, her bloodwork and a CT scan of her head were normal. (R. at 437, 439.) Culbertson was diagnosed as suffering from atypical paresthesias and noncardiac chest pain. (R. at 437.) She was told to start taking an aspirin daily and prescribed Antivert for her complaints of vertigo and Valium for anxiety. (R. at 438, 844.)

Culbertson saw Dr. Wilson on March 27, 2006, for follow up. (R. at 399-401.) Dr. Wilson noted that Culbertson was doing well on Vytorin for her high cholesterol and Lunesta for her insomnia. (R. at 400.) He also noted that Culbertson could not tolerate Effexor for her depression and was back on Zoloft. (R. at 400.) Culbertson complained of chest wall discomfort. (R. at 400.) Dr. Wilson noted that the pain was reproducible; he stated that Culbertson's left upper chest intercostal muscles were irritated. (R. at 400.) Dr. Wilson noted that it had been determined that Culbertson had not suffered a heart attack on March 6. (R. at 400.)

Culbertson was seen at the Urgent Care Clinic on May 9, 2006, by Alan Dobbs, F.N.P., and Dr. Robert M. Geer, M.D. (R. at 404-06.) Culbertson complained of sharp chest pain, worse when lying on her left side and with deep inspiration. (R. at 404.) Culbertson said the pain radiated into her left jaw and

neck. (R. at 404.) Culbertson said she felt like she was smothering when she would lie down and was unable to lie on her left side. (R. at 404.) She said prescription ibuprofen did not ease her pain. (R. at 404.) X-rays of Culbertson's chest taken on May 9, 2006, showed no evidence of active pulmonary disease and small degenerative osteophytes involving the mid thoracic spine. (R. at 403.) Otherwise, her bony structures were unremarkable. (R. at 403.) Culbertson was diagnosed as suffering from costochondritis and given an injection of dexamethasone. (R. at 405.)

Culbertson returned to see Dr. Wilson on May 31, 2006, complaining of a bad headache. (R. at 407-08.) Dr. Wilson noted that Culbertson was ambulatory with a steady gait and free of acute injury, able to move all extremities with full ranges of motion and no pain on movement and had no edema of the extremities. (R. at 408.) Dr. Wilson diagnosed a migraine headache and ordered an injection of Demerol and Phenergan. (R. at 408.)

Culbertson saw Dr. Allen Chan, M.D., with HMG, on September 21, 2006. (R. at 409-10.) Culbertson complained of mid-epigastric discomfort for the previous five days or more. (R. at 409.) Culbertson described the pain as a burning, gnawing-type sensation that was the same type of feeling she had when she previously had been diagnosed with H. pylori. (R. at 409.) Culbertson stated that she was under a lot of stress and also complained of chest pain radiating into her left arm. (R. at 409.) An EKG showed normal sinus rhythm with no acute changes. (R. at 410.) Dr. Chan diagnosed reflux disease and prescribed Prilosec and Zantac and stated that he would refer Culbertson to a gastroenterologist. (R. at 410.)

Culbertson returned to see Dr. Wilson for her six-month follow-up on September 27, 2006. (R. at 411-12.) Dr. Wilson's exam of Culbertson was normal in all areas. (R. at 412.) Culbertson complained of mid-epigastric pain, which Dr. Wilson noted might be recurrent *H. pylori*. (R. at 412.) He ordered testing to confirm this, and he noted that Culbertson had an appointment with a gastroenterologist. (R. at 412.) Dr. Wilson also noted that Culbertson was feeling a little overwhelmed due to family problems. (R. at 412.)

Culbertson saw Dr. Jerry F. London, M.D., on October 5, 2006, for complaints of reflux for the previous three years. (R. at 531-33.) Culbertson stated that she took omeprazole, which helped her symptoms some. (R. at 531.) Culbertson also complained of bright red blood in her stool and a history of hemorrhoids. (R. at 531.) Dr. London diagnosed gastroesophageal reflux disease with epigastric pain. (R. at 533.) Dr. London ordered an endoscopy and colonoscopy. (R. at 533.) The endoscopy and colonoscopy were performed on October 9, 2006, with normal results except for revealing a gastric ulcer. (R. at 810-11.)

Culbertson was seen at the Urgent Care Clinic on October 8, 2006, with complaints of intense itching with rash on hands, arms and torso. (R. at 413.) Dr. Wilson ordered a Decadron shot and an increased dosage of diazepam. (R. at 413-14.)

Culbertson was seen by a physician with Dermatology Associates on October 10, 2006, for a rash on her trunk and extremities. (R. at 809.) The physician prescribed Allegra, ranitidine and hydroxyzine. (R. at 809.)

A CT scan of Culbertson's pelvis with contrast taken on November 2, 2006, was normal except for two cysts on her liver and some small diverticula in her sigmoid colon. (R. at 549-50.)

Culbertson saw Dr. James Bryston Winegar, M.D., and Dr. Sidi Noor, M.D., with the Urgent Care Clinic, on November 26, 2006, for head and chest congestion, cough and fever. (R. at 804-05.) The physicians diagnosed acute sinusitis and wrote Culbertson prescriptions for an antibiotic, decongestant and cough medicine. (R. at 805.)

Culbertson saw Dr. Geer at the Urgent Care Clinic on February 5, 2007, for complaints of nausea, abdominal pain, urgency to urinate, burning sensation on urination and foul-smelling urine. (R. at 801-03.) Dr. Geer noted that Culbertson's abdomen was tender over her bladder. (R. at 802.) Dr. Geer diagnosed bladder spasm with nausea secondary to the pain. (R. at 803.)

Culbertson returned to Dr. Wilson for her six-month follow-up appointment on March 28, 2007. (R. at 421-23.) Culbertson complained of being under pressure due to family issues. (R. at 422.) Dr. Wilson increased her dosage of Zoloft. (R. at 422.) Culbertson also complained of a persistent urinary tract infection. (R. at 422.) Dr. Wilson prescribed Elmiron to address this complaint. (R. at 422.) Dr. Wilson also ordered some bloodwork to address Culbertson's complaint of increased joint pain. (R. at 422.)

On May 8, 2007, Culbertson returned to Dr. Wilson complaining of bilateral pain in her groin area that radiated into her lower back. (R. at 424.) Culbertson said

that she had discontinued use of Elmiron because it made her nauseous. (R. at 424.) She also complained of heart palpitations with loss of breath. (R. at 425.) Dr. Wilson ordered pelvic and abdominal ultrasounds. (R. at 425.) No abnormalities were noted on these tests. (R. at 429-30, 465.)

Culbertson was seen at the Holston Valley Medical Center Emergency Department for abdominal pain on July 12, 2007. (R. at 442.) A CT scan was negative for any evidence of kidney stones and showed a normal appendix. (R. at 443-444, 518.) Dr. Wilson saw Culbertson on July 17, 2007, in follow-up from this emergency department visit. (R. at 764-65.) In addition to pelvic pain, Culbertson complained of rectal bleeding. (R. at 764.) Dr. Wilson noted that there was some evidence of a slight urinary tract infection, for which he prescribed an antibiotic. (R. at 765.)

State agency psychologist Joseph I. Leizer, Ph.D., completed a Psychiatric Review Technique form, ("PRTF"), on Culbertson on July 19, 2007, based on her then-current condition. (R. at 451-63.) Leizer stated that Culbertson suffered from an affective disorder and anxiety-related disorder, which were not severe. (R. at 451.) Leizer stated that Culbertson had no restriction of her activities of daily living, no difficulties in maintaining social functioning, no difficulties in maintaining concentration, persistence or pace and had experienced no repeated episodes of decompensation of extended duration. (R. at 461.) Leizer opined that Culbertson was able to perform the mental demands of all levels of work. (R. at 463.)

Dr. Chadi Jarjoura, M.D., a gynecologist, saw Culbertson on May 24, 2007,

for complaints of pain in lower abdominal area radiating into her back for the previous two months. (R. at 772-74.) Culbertson described the pain as occasional and sharp. (R. at 772.) Culbertson rated the pain an 8-10 on a 10-point scale. (R. at 772.) Dr. Jarjoura saw Culbertson again on June 20, 2007, for a urodynamic procedure. (R. at 769-70.) Dr. Jarjoura diagnosed stress incontinence and intrinsic sphincter deficiency with small bladder capacity. (R. at 770.) Culbertson returned to Dr. Jarjoura on September 10, 2007, for follow-up to bladder complaints. (R. at 758-59.) Dr. Jarjoura again diagnosed stress incontinence and intrinsic sphincter deficiency with small bladder capacity. (R. at 759.)

State agency psychologist E. Hugh Tenison, Ph.D., completed a PRTF on Culbertson on November 5, 2007, based on her then-current condition. (R. at 468-81.) Tenison stated that Culbertson suffered from an affective disorder and anxiety-related disorder, which were not severe. (R. at 468.) Tenison stated that Culbertson had no restriction of her activities of daily living, no difficulties in maintaining social functioning, mild difficulties in maintaining concentration, persistence or pace and had experienced no repeated episodes of decompensation of extended duration. (R. at 478.) Tenison opined that Culbertson was able to perform the mental demands of all levels of work. (R. at 481.)

State agency physician Dr. Joseph Duckwall, M.D., completed a Physical Residual Functional Capacity Assessment on Culbertson on November 6, 2007. (R. at 482-86.) Dr. Duckwall stated that Culbertson's primary diagnosis was tachycardia, and her secondary diagnosis was abdominal pain. (R. at 482.) Dr. Duckwall opined that Culbertson could occasionally lift and carry items weighing up to 50 pounds and frequently lift and carry items weighing up to 25 pounds. (R.

at 483.) He stated that Culbertson could stand and walk for a total of about six hours and sit for a total of about six hours in an eight-hour workday. (R. at 483.) He stated that Culbertson's ability to push and pull was unlimited. (R. at 483.) Dr. Duckwall stated that Culbertson could occasionally climb ramps and stairs, but should never climb ladders, ropes or scaffolds. (R. at 484.) He stated that Culbertson could frequently balance, stoop, kneel, crouch and crawl. (R. at 484.) Dr. Duckwall stated that Culbertson had no manipulative limitations, no visual limitations and no communicative limitations. (R. at 484-85.) Dr. Duckwall said that Culbertson should avoid concentrated exposure to hazards such as machinery and heights, but had no other environmental limitations. (R. at 485.)

Culbertson saw Dr. Wilson on December 7, 2007, for routine follow up. (R. at 756-57.) Dr. Wilson noted that anxiety was an ongoing issue. (R. at 757.) Culbertson saw Dr. Wilson again on April 10, 2008, for a routine check up and renewal of her medications. (R. at 750-51.) Dr. Wilson stated that Culbertson's complaints of chest pain were likely stress induced. (R. at 751.) Dr. Wilson ordered a cardiac stress test. (R. at 751.)

Dr. Sitaram G. Kadekar, M.D., a cardiologist, saw Culbertson on May 6, 2008, with complaints of chest pain, palpitations and shortness of breath. (R. at 722-25.) Culbertson gave a history of pain in the left breast region for the previous two to three months. (R. at 723.) Culbertson said the pain was random, would last for five to 10 minutes and was a 5 or 6 on a 10-point scale. (R. at 723.) She said the pain did not increase with exertion. (R. at 723.) Culbertson claimed that her heart "raced" several times a day on a daily basis. (R. at 723.) Culbertson said she had difficulty walking across a parking lot due to shortness of breath, which worsened

with exertion. (R. at 723.) Dr. Kadekar noted that Culbertson had undergone a cardiac stress test with negative results on April 22, 2008. (R. at 723, 726-27, 740-41, 747, 749.) Dr. Kadekar also noted that Culbertson had retired from nursing. (R. at 723.) Dr. Kadekar also noted that Culbertson appeared very anxious and exhibited “repeating sighing-type of breathing.” (R. at 724.) Dr. Kadekar arranged further testing, including chest X-rays, echocardiography, 24-hour Holter monitoring and ankle-brachial index studies. (R. at 724.)

Culbertson saw Dr. Wilson for coughing and wheezing on June 4, 2008. (R. at 718-19.) Culbertson also complained of increased shortness of breath. (R. at 719.) Dr. Wilson diagnosed bronchitis and ordered a Rocephin shot and prescriptions for an antibiotic, a nebulizer, an inhaler and a cough syrup. (R. at 719.) An X-ray taken that day showed clear lungs except for minor fibrotic changes scattered throughout. (R. at 720.)

Culbertson saw Dr. Wilson for follow-up on July 10, 2008. (R. at 712-14.) Culbertson complained of increasing shortness of breath. (R. at 713.) In fact, Culbertson said that she was not able to exert herself in a meaningful way without getting very short of breath. (R. at 713.) Dr. Wilson noted that Culbertson’s hypertension was under excellent control. (R. at 713.) Dr. Wilson also administered a steroid injection into Culbertson’s right thumb. (R. at 713.)

Culbertson saw Dr. Charlene Grigsby, M.D., on July 16, 2008, for complaints of nausea and diarrhea without vomiting. (R. at 707-08.) Culbertson denied any decreased appetite or abdominal pain. (R. at 708.) Dr. Grigsby diagnosed gastroenteritis. (R. at 708.)

Pulmonary function testing performed July 24, 2008, was interpreted by Dr. Bruce S. Grover, M.D., as normal. (R. at 704-06.)

Culbertson saw Dr. Wilson for a possible urinary tract infection on September 3, 2008. (R. at 700-01.) Culbertson also complained of being very depressed due to the recent death of her brother. (R. at 701.) Dr. Wilson stated that there was no evidence of a urinary tract infection, but he did add trazodone to address Culbertson's depression. (R. at 701.)

Culbertson saw Dr. Lauren Franklin, M.D., on September 15, 2008, complaining of hurting all over, passing blood in her urine, headache and chilling. (R. at 693-95.) Culbertson said that she was under a lot of stress, and Dr. Franklin noted that she was very anxious and almost tearful at times. (R. at 693.) Dr. Franklin ordered bloodwork and a urinalysis, a Rocephin shot, a shot for pain and wrote a prescription of Levaquin. (R. at 695.) An ultrasound of Culbertson's gallbladder performed on September 19, 2008, showed no gall stones but did reveal a cyst on her liver. (R. at 697.)

Culbertson saw Dr. Jerry F. London, M.D., with Gastroenterology Associates, on September 18, 2008. (R. at 528-30.) Dr. London noted that Culbertson's chief complaint was constant diarrhea of two months' duration. (R. at 528.) She complained of upwards of 50 watery bowel movements a day. (R. at 528.) Nonetheless, Culbertson said that she had gained 20 pounds over the previous year. (R. at 528.) Culbertson also reported a history of ankle swelling, chest pain, shortness of breath, heart palpitations, lower abdominal pain, belching, bloating, flatulence, heartburn, hemorrhoids and rectal urgency with

soiling/incontinence. (R. at 529.) Dr. London also noted that Culbertson complained of anxiety/panic, depression, inability to concentrate and suicidal thoughts. (R. at 530.) Dr. London diagnosed irritable bowel syndrome, ordered lab work and a sigmoidoscopy and prescribed dicyclomine. (R. at 530.) A stool sample collected September 19, 2008, from Culbertson tested negative for clostridium difficile or “c-diff,” parasites and rotavirus antigen. (R. at 672, 673, 674.)

A sigmoidoscopy with biopsy was performed on Culbertson on September 22, 2008, at Holston Valley Medical Center by Dr. London. (R. at 507-08.) Dr. London noted that Culbertson suffered from chronic irritable bowel syndrome, but that the procedure was performed due to recently developing frequent diarrhea. (R. at 507.) The pathology report for the biopsy specimens noted no microscopic evidence of colitis. (R. at 509.) Dr. London also performed an endoscopy and colonoscopy on Culbertson on October 9, 2006. (R. at 540-41.) The endoscopy revealed a gastric ulcer, but the colonoscopy was normal. (R. at 540-41.)

Culbertson saw Dr. Franklin on October 6, 2008, for follow-up for a urinary tract infection. (R. at 667-69.) Culbertson complained of intermittent chest pain relieved with the use of nitroglycerine. (R. at 667.) Culbertson also complained of pain in her legs so bad that she could not walk on occasion and lower back pain. (R. at 667.) Culbertson was referred for a cardiology consult. (R. at 669.)

Dr. Kadekar saw Culbertson on October 15, 2008. (R. at 510-13.) Culbertson complained of increasing episodes of chest discomfort, often associated with exertion, relieved by rest and nitroglycerin, shortness of breath and recurrent bouts of palpitations. (R. at 510.) Dr. Kadekar noted that Culbertson’s EKG,

nuclear myocardial perfusion study, echocardiography and Holter monitor testing all were negative. (R. at 510.) Dr. Kadekar's examination showed that pressure over the costochondral junction region in the left sternal location reproduced Culbertson's complaints of the sudden, sharp, momentary atypical chest pain. (R. at 511.) Dr. Kadekar stated that it was more than likely that Culbertson had no significant coronary artery disease. (R. at 512.) Nonetheless, Culbertson stated that she wanted to undergo cardiac catheterization to ensure that she did not. (R. at 512.)

This cardiac catheterization was performed at Holston Valley Medical Center by Dr. Marc Mayhew, M.D., on October 16, 2008. (R. at 514-15.) Other than some moderate mitral valve regurgitation, the catheterization showed normal heart function with no coronary artery disease. (R. at 514-15.)

Dr. Wilson saw Culbertson on November 5, 2008, for complaints of swelling and discomfort in her lower leg. (R. at 652-54.) Dr. Wilson stated that this might be due to inflammation from recent heart catheterization. (R. at 653.) Culbertson was very depressed and said she was sleeping a lot. (R. at 653.) An ultrasound of Culbertson's right lower leg performed on November 5, 2008, was negative for any signs of a blood clot. (R. at 656.)

Dr. Wilson saw Culbertson on December 3, 2008, for follow-up. (R. at 648-49.) Dr. Wilson noted that Culbertson had a flat affect and was depressed and withdrawn. (R. at 649.) Culbertson complained of chest discomfort, which Dr. Wilson attributed likely due to stress. (R. at 649.) Dr. Wilson noted that Culbertson was depressed and not doing well. (R. at 649.) He added Effexor, discontinued her

Valium prescription and prescribed Xanax. (R. at 649.)

A CT scan of Culbertson's abdomen with and without contrast performed on January 26, 2009, revealed normal results with the exception of fatty infiltration of the liver and a right lobe cyst. (R. at 671.)

Dr. Wilson saw Culbertson on January 30, 2009, for a follow-up appointment. (R. at 645-47.) Culbertson complained of continuing urinary symptoms, including burning with urination, hurting in her lower back and a foul odor to her urine. (R. at 645.) Dr. Wilson prescribed Cipro to treat Culbertson's urinary tract infection. (R. at 646.) He also noted that Culbertson was "very stressed," and her depression was not well-controlled. (R. at 646.) Dr. Wilson increased Culbertson's Effexor dosage. (R. at 646.)

Culbertson saw Mitzi Musick, a nurse practitioner, for complaints of shortness of breath and left-sided chest discomfort and nausea on February 24, 2009. (R. at 635-37.) Culbertson reported that her anxiety and depression were controlled with her then-current medicine regimen. (R. at 635.) Culbertson also wanted to be checked for a urinary tract infection. (R. at 635.) Musick ordered chest X-rays and a CT scan along with lab work. (R. at 637.) The chest X-rays were normal. (R. at 639.)

Culbertson saw Dr. Franklin on March 26, 2009, for complaints of shortness of breath and atypical chest pain, which she noted had been extensively evaluated. (R. at 630-32.) Culbertson reported numerous stressors in her life. (R. at 630.) Dr. Franklin recommended a physical therapy consultation for deconditioning, but

Culbertson canceled her appointment stating that she did not want to do therapy. (R. at 629, 631.) Culbertson saw Dr. Franklin again on April 27, 2009, for complaints of shortness of breath and atypical chest pain. (R. at 626-28.) Dr. Franklin stated that Culbertson's work-up to date had been negative. (R. at 626.) Dr. Franklin recommended referral for a pulmonology consultation. (R. at 627.)

Janice F. Ewing, F.N.P., with Pulmonary Associates of Kingsport, saw Culbertson on May 4, 2009, for pulmonary consultation for complaints of shortness of breath. (R. at 613-15.) Culbertson gave a history of pneumonia within the past year and said she had been short of breath since then. (R. at 613.) Culbertson complained of headaches, dizziness, nasal/sinus congestion, chest pain, palpitations, ankle and leg swelling, heartburn, diarrhea, blood in stool, difficulty coping with stress, joint pain, skin changes and hair loss, depression and anxiety and insomnia. (R. at 614.)

Culbertson returned to see Ewing on May 18, 2009, for complaints of shortness of breath and mid-sternal chest discomfort radiating down her left arm. (R. at 610-11.) Ewing noted that a recent extensive cardiac work-up was negative. (R. at 610.) Pulmonary function testing was normal. (R. at 610.) A CT scan of Culbertson's chest also was normal. (R. at 610.) Ewing noted no evidence of lung disease. (R. at 611.) Ewing suggested that Culbertson might be experiencing panic attacks. (R. at 611.)

Culbertson was seen by the Urgent Care Clinic on June 9, 2009, for complaints of a urinary tract infection. (R. at 606-08.) Dr. Alfred L Harkleroad, M.D., prescribed an antibiotic for her infection. (R. at 608.)

Culbertson saw Dr. Bryan Arnette, M.D., on June 22, 2009, for complaints of black discolored stools. (R. at 601-03.) She also complained of stomach pain with nausea, but no vomiting. (R. at 601.) A hemoccult test was negative for blood in Culbertson's stool. (R. at 603.) Dr. Arnette recommended that she follow up with her gastroenterologist, and he diagnosed a urinary tract infection. (R. at 603.)

Culbertson saw Saylor on July 2, 2009, for complaints of blood in her stool. (R. at 525-27.) Saylor noted that Culbertson's lab work was within normal limits with no anemia. (R. at 525.) Saylor also noted that Culbertson had a colonoscopy in 2006 with normal results and a sigmoidoscopy in September 2008 with normal results. (R. at 525.) Culbertson complained of rectal pain and pressure and lower abdominal pain, usually only with bowel movements. (R. at 525.) She also complained of fatigue, heartburn/reflux, chest pain and irregular heart beat, shortness of breath, urinary tract infection, joint and muscle pain and weakness and dizziness. (R. at 525-26.) Culbertson also complained of difficulty sleeping, but denied any anxiety/panic or depression. (R. at 526.) Saylor noted that her exam showed an anal tear. (R. at 527.)

Culbertson was seen at the Urgent Care Clinic on July 24, 2009, by Dr. Timothy J. Berrigan, M.D., for complaints of lower back and right side pain. (R. at 587-89.) Dr. Berrigan ordered a CT scan of Culbertson's abdomen and pelvis and referred her to the emergency room for management of her complaints of pain. (R. at 589-90.)

Culbertson presented to the Holston Valley Medical Center emergency department on July 24, 2009, complaining of right flank and abdominal pain. (R. at

574-76.) A CT scan of Culbertson's abdomen and pelvis performed on July 24, 2009, showed no evidence of kidney stones or any obstruction in her urinary tract, fatty infiltration of the liver with a cyst and several sigmoid diverticula. (R. at 572.)

Culbertson saw Dr. Franklin on December 24, 2009, requesting refills on her medications and complaining of blood in her stool. (R. at 566-68.) On this occasion, Culbertson said she only occasionally suffered mild chest pain and mild shortness of breath. (R. at 566.) Culbertson also complained of increased joint pain in the hands and lower back and increased anxiety. (R. at 566.) Dr. Franklin recommended Culbertson see her gastroenterologist, increased her dosage of Xanax and gave her a prescription for Darvocet for pain. (R. at 568.)

Culbertson returned to Saylor on February 11, 2010, with complaints of irritable bowel syndrome and rectal bleeding. (R. at 522-24.) Saylor noted that Culbertson was seen in 2009 for similar complaints. (R. at 522.) Culbertson complained of loss of appetite, rectal bleeding, constipation, abdominal pain, rectal pain and nausea. (R. at 523.) Culberston also gave a history of frequent urinary tract infections, joint and back pain, dizziness, frequent headaches and vertigo. (R. at 523.) Saylor diagnosed irritable bowel syndrome. (R. at 524.) Saylor prescribed a laxative and topical ointment for rectal pain. (R. at 524.)

Culbertson saw a physician on February 18, 2010, complaining of a possible urinary tract infection with urgency, pressure and lower back pain. (R. at 554-56.)⁶ She was prescribed an antibiotic. (R. at 556.)

⁶ This report appears to be from the Holston Medical Group, but it is not signed. (R. at 554-56.)

State agency physician Dr. Joyce Goldsmith, M.D., completed a Physical Residual Functional Capacity Assessment on Culbertson on June 3, 2010, based on Culbertson's then-current condition. (R. at 903-09.) Dr. Goldsmith noted that Culbertson's primary diagnosis was chest pain, tachycardia, and her secondary diagnosis was shortness of breath with another alleged impairment of abdominal pain. (R. at 903.) Dr. Goldsmith stated that Culbertson could occasionally lift and carry items weighing up to 50 pounds and frequently lift and carry items weighing up to 25 pounds. (R. at 904.) Dr. Goldsmith did not place any limitation on Culbertson's ability to stand and walk. (R. at 904.) She stated that Culbertson could sit with normal breaks for less than six hours in an eight-hour workday. (R. at 904.) Dr. Goldsmith stated that Culbertson's ability to push and pull was limited to the weights she could lift and carry. (R. at 904.) Dr. Goldsmith stated that Culbertson could occasionally climb ladders, ropes and scaffolds and frequently climb ramps and stairs, balance, stoop, kneel, crouch and crawl. (R. at 905.) Dr. Goldsmith stated that Culbertson had no manipulative, visual or communicative limitations. (R. at 906-07.) She stated that Culbertson should avoid concentrated exposure to hazards such as machinery and heights. (R. at 906.)

Culbertson saw Dr. Frederick A. Klein, M.D., a urologist, on August 5, 2010, for complaints of chronic pelvic pain. (R. at 910.) Dr. Klein ordered a cystoscopy and hydrodistention tests. (R. at 910.) These tests were performed on August 9, 2010, by Dr. Klein assisted by Dr. Ryan B. Pickens, M.D.. (R. at 915, 917.) A biopsy of Culbertson's bladder tissue performed on August 9, 2010, showed evidence of mild chronic cystitis. (R. at 912-13.) A urine culture taken from Culbertson on August 19, 2010, showed no growth in 16-24 hours. (R. at

911.)

Culbertson returned to see Dr. Klein on August 19, 2010. (R. at 920.) Culbertson complained of dysuria, chills, frequency and urgency. (R. at 920.) Culbertson said she was “miserable” and was crying. (R. at 920.) Dr. Klein noted that the procedures performed on August 9 were negative for abnormalities. (R. at 920.) Dr. Klein diagnosed pelvic pain and prescribed Cipro and Pyridium. (R. at 920.)

At the request of the state agency, Culbertson saw B. Wayne Lanthorn, Ph.D., a licensed clinical psychologist, for a consultative evaluation on August 23, 2010. (R. at 925-31.) Culbertson told Lanthorn that she was disabled due to nerves, depression, anxiety, tachycardia, and post-traumatic stress disorder due to sexual abuse. (R. at 925.) Lanthorn stated that Culbertson was oriented in all spheres. (R. at 925.) Culbertson said that she had last worked as a certified nursing assistant in 2003. (R. 926.)

Culbertson said that her treating physician, Dr. Burns, had prescribed Xanax, Zoloft and Effexor for her psychological symptoms. (R. at 927.) Lanthorn noted that Culbertson’s affect was mixed, and she cried frequently during the interview, was agitated, tense, on edge, fidgety and had a mild to moderate tremulousness of her hands. (R. at 927.) He described her mood as agitated depression. (R. at 927.) Lanthorn stated that Culbertson showed no clear clinical signs of ongoing psychotic processes, nor any evidence of delusional thinking. (R. at 928.) Culbertson did report visual hallucinations of seeing her brother on occasion after his death. (R. at 928.)

Culbertson gave a history of sexual abuse as a child. (R. at 928.) She said that a young relative had recently been molested and this had reopened her earlier trauma. (R. at 928.) Culbertson stated that she had been depressed all of her life. (R. at 928.) She stated that her medication had helped somewhat, but that she often felt depressed, cried on a nearly daily basis, had little energy, no sex drive, was often irritable and preferred to be alone. (R. at 928.) Culbertson denied any then current suicidal or homicidal ideations, but she did report one suicide attempt in 1993. (R. at 928.) She complained of poor short-term memory and somewhat erratic concentration. (R. at 928.)

Culbertson complained of nightmares about her sexual abuse. (R. at 928.) She said she suffers from an exaggerated startle response and worries a great deal. (R. at 928.) She said that she felt somewhat detached and estranged. (R. at 928.) She said she had insomnia and hypervigilance. (R. at 928.) Culbertson said she experienced generalized anxiety, frequently felt tense and on edge and had had panic attacks since childhood. (R. at 929.) Culbertson said that she suffered from two to three panic attacks a week, even with medication. (R. at 929.) During these attacks, Culbertson said she would hyperventilate and become short of breath, her heart would race, she became sweaty, hot in the face and nauseated. (R. at 929.) Culbertson said these symptoms would last for an hour or longer. (R. at 929.)

Lanthorn opined that Culbertson functioned in the borderline range intellectually. (R. at 929.) Lanthorn diagnosed Culbertson with post-traumatic stress disorder, chronic; major depressive disorder, recurrent, moderate to severe; panic disorder without agoraphobia; and generalized anxiety disorder. (R. at 929.)

Lanthorn placed Culbertson's then-current Global Assessment of Functioning⁷ at 50-55.⁸ (R. at 930.) Lanthorn stated that Culbertson was competent to manage her own funds. (R. at 930.) Lanthorn stated that Culbertson's prognosis was quite guarded based on the longevity, severity and complexity of her psychopathology. (R. at 930.) He encouraged Culbertson to return to psychiatric and psychotherapeutic intervention as soon as possible. (R. at 930.)

Lanthorn stated that Culbertson could learn simple tasks with almost no limitations, but more complicated tasks on a routine basis would present mild to moderate limitations. (R. at 930.) He stated that Culbertson would have moderate to marked limitations interacting with supervisors, co-workers and the general public. (R. at 930.) Lanthorn stated that Culbertson would have moderate or greater limitations in sustaining concentration and persisting effectively at tasks. (R. at 931.) He also stated that Culbertson would have moderate limitations in dealing with changes and the requirements of the workplace. (R. at 931.)

A CT of Culbertson's abdomen performed on October 14, 2010, showed no kidney stones and was normal other than showing diffuse fatty infiltration of the liver with a liver cyst. (R. at 951.) Culbertson was seen in the emergency department of Indian Path Medical Center on November 16, 2010, with complaints

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).

⁸ A GAF score of 41-50 indicates that the individual has serious symptoms or serious impairments in social, occupational, or school functioning. *See* DSM-IV at 32. A GAF score of 51-60 indicates that the individual has moderate symptoms or moderate difficulty in social, occupational, or school functioning. *See* DSM-IV at 32.

of pelvic pain since February. (R. at 940-44, 947.) Culbertson was given prescriptions for Cipro and Anaprox and discharged to home. (R. at 944.)

Culbertson saw Dr. Octavio J. Pinell, M.D., with East TN OB/GYN Associates, on November 9, 2010, complaining of left lower quadrant pain. (R. at 977-78.) Much of Dr. Pinell's handwritten medical record of this appointment is illegible except that Culbertson did not want to undergo an exploratory laparotomy. (R. at 978,)

Culbertson returned to Dr. Pinell on December 20, 2010. (R. at 986.) Dr. Pinell noted that the type of pain Culbertson experienced was often caused by adhesions. (R. at 986.) Dr. Pinell noted that he was going to refer Culbertson to Dr. Withrow for a second opinion. (R. at 986.) Culbertson saw Dr. Mark L. Withrow, M.D., on January 5, 2011. (R. at 985.) Culbertson told Dr. Withrow that she experienced chronic, constant, sharp stabbing pain, which was exacerbated by any type of physical activity. (R. at 985.) Dr. Withrow noted that Culbertson began to cry due to pain during her pelvic exam. (R. at 985.) Dr. Withrow recommended physical therapy. (R. at 985.)

Culbertson saw Dr. Withrow again on February 7, 2011. (R. at 984.) Culbertson told Dr. Withrow that physical therapy made her pain worse. (R. at 984.) Dr. Withrow stated that he was not convinced that Culbertson's complaints of pain were caused by adhesions. (R. at 984.) Dr. Withrow stated that, on physical examination, Culbertson's abdomen was generalized tender. (R. at 984.) He also stated that the exam was somewhat limited secondary to Culbertson's "body habitus." (R. at 984.) Dr. Withrow recommended a referral for a neurosurgical

consultation. (R. at 984.)

Culbertson returned to Dr. Withrow on April 27, 2011, to schedule a diagnostic laparoscopy. (R. at 983.) Culbertson had her pre-op consultation with Dr. Withrow on May 4, 2011, (R. at 982.) Dr. Withrow performed a diagnostic laparoscopy with lysis of adhesions on Culbertson on May 5, 2011. (R. at 987-88.) Dr. Withrow noted numerous adhesions, some of which he was unable to dissect. (R. at 987.) Culbertson saw Dr. Withrow for post-op appointment on May 18, 2011. (R. at 981.) Culbertson said she was doing pretty well, but still had a little discomfort. (R. at 981.) Dr. Withrow stated that he was unsure whether Culbertson was experiencing post-operative healing pain or pain related to her adhesions. (R. at 981.)

State agency physician Dr. John Sadler, M.D., also completed a Physical Residual Functional Capacity Assessment of Culbertson on January 21, 2011. (R. at 144-46.)⁹ Dr. Sadler opined that, prior to her date last insured, Culbertson could occasionally lift and carry items weighing up to 50 pounds, frequently lift and carry items weighing up to 25 pounds, stand and walk about six hours and sit about six hours in an eight-hour workday, push and pull up to her lift and carry limitations, occasionally climb ladders, ropes and scaffolds and frequently climb ramps and stairs, stoop, kneel, crouch and crawl. (R. at 144-45.) He also stated that Culbertson had no manipulative, visual or communicative limitations, and her only environmental limitation was to avoid concentrated exposure to hazards such as

⁹ The only evidence of this assessment contained in the Administrative Record is the summary of the assessment contained in the Disability Determination Explanation on reconsideration. (R. at 144-46.)

machinery and heights. (R. at 145-46.)

State agency psychologist, Louis Perrott, Ph.D., completed a PRTF on Culbertson on January 24, 2011. (R. at 143.)¹⁰ Perrot stated that, as of Culbertson's last insured date, December 31, 2008, she suffered from an affective disorder and anxiety disorder that were not severe. (R. at 143.) Perrot opined that there was insufficient evidence in the record to rate Culbertson's mental limitations. (R. at 143.)

Culbertson saw Dr. Sheldon H. Fisher, D.O., on July 18, 2011, for continuing complaints of low abdominal and pelvic pain. (R. at 980.) Dr. Fisher noted that Culbertson had undergone a laparoscopy in May with lysis of multiple adhesions. (R. at 980.) Nonetheless, he noted that Culbertson continued to complain of pain. (R. at 980.) Dr. Fisher stated that he was going to schedule Culbertson for a test to determine if her pain was caused by her bladder. (R. at 980.)

A CT scan of Culbertson's abdomen and pelvis performed on September 2, 2011, showed no acute process. (R. at 936.) The image revealed diffuse fatty infiltration of the liver with a cyst on the right lobe of the liver. (R. at 936.) There also was noted sigmoid diverticulosis with no evidence of diverticulitis. (R. at 936.)

¹⁰ The only evidence of this PRTF contained in the Administrative Record is the summary of it contained in the Disability Determination Explanation on reconsideration. (R. at 143.)

Culbertson saw Dr. C. Glenn Trent, Jr., M.D., with Appalachian Orthopaedic Associates, P.C., on February 14, 2011, for a chief complaint of bilateral groin and back pain of one year's duration. (R. at 965.) Culbertson denied any radiating, chest or abdominal pain. (R. at 965.) Culbertson said that sweeping, mopping, walking, standing and climbing stairs aggravated the pain. (R. at 965.) She also stated that physical therapy only made the pain worse. (R. at 965.) Dr. Trent noted that Culbertson could heel and toe walk with good balance, her strength was 5/5 and she had no joint swelling. (R. at 965.) He did note that Culbertson's reflexes in her patella and Achilles tendon were trace. (R. at 965.) X-rays of Culbertson's back and pelvis taken on February 14 showed some mild degenerative disc disease at the L5-S1 and L4-L5 levels and a relatively normal pelvis for her age. (R. at 964.) Dr. Trent ordered an MRI of Culbertson's back and pelvis. (R. at 965.)

An MRI of Culbertson's spine was performed on September 21, 2011, and revealed a right foraminal disc protrusion at the L4-L5 level with compromise of the right L4-L5 neuroforamen; posterior disc bulge, bilateral foraminal stenosis and left foraminal disc protrusion at the L5-S1 level; small synovial cysts at the L5-S1 facet joints; minimal L3-L4 posterior disc bulge; and disc desiccation changes throughout her spine. (R. at 959, 968.)

Culbertson returned to see Dr. Trent on September 26, 2011. (R. at 963.) Dr. Trent noted that Culbertson had an abdominal procedure with lysis of adhesions that had helped the pain in her lower abdomen/groin area. (R. at 961.) Dr. Trent noted that the MRI of Culbertson's spine showed multiple-level disc degeneration with a left foraminal L5 disc protrusion, but he said that this defect did not match

any of Culbertson's symptoms. (R. at 961.) Dr. Trent said that these findings did not explain her groin or abdominal pain. (R. at 961.) He again ordered an MRI of Culbertson's pelvis. (R. at 961.)

Culbertson returned to see Dr. Trent on October 10, 2011. (R. at 962.) Dr. Trent stated that Culbertson's MRI of her pelvis was normal except for the tiny cyst on her left hip. (R. at 961-62, 967.) Dr. Trent noted that Culbertson had some degenerative disc disease with left-sided disc herniation, but that did not describe Culbertson's pain pattern. (R. at 962.) Dr. Trent stated that he thought Culbertson's abdominal pain was coming from abdominal scar tissue and not her back. (R. at 962.) He noted that Culbertson refused referral into pain management. (R. at 962.)

Culbertson saw Dr. Withrow again on November 9, 2011. (R. at 979.) Dr. Withrow noted that Culbertson "did not really get much relief with the lysis of adhesions." (R. at 979.) Dr. Withrow stated that Culbertson had been through a "tremendous workup" for her complaints of abdominal pain. (R. at 979.) Dr. Withrow noted that she had undergone orthopedic and gastroenterological consultations and testing with no explanation for her continuing complaints of abdominal pain. (R. at 979.) Dr. Withrow recommended that Culbertson be referred to a pain management specialist. (R. at 979, 991.)

Culbertson saw Rona C. Addington, A.P.N., with the Pain Center of Kingsport on May 7, 2012, for lower back pain. (R. at 1024-26.) Culbertson also complained of intermittent throbbing abdominal/groin pain, which was worse with standing. (R. at 1024.) Culbertson's goals were listed as increasing her function level and decreasing her pain. (R. at 1025.) Addington noted a history of a suicide

attempt in 1993. (R. at 1025.) Addington administered a lidocaine injection in Culbertson's lumbar spine at the L5 level. (R. at 1026.)

Culbertson's attorney submitted additional medical reports from Dr. Nerissa Licup, M.D., of Mountain States Medical Group Family Medicine-Internal Medicine of Kingsport, to the Appeals Counsel. (R. at 12-70.) According to these reports, Culbertson saw Dr. Licup for a follow-up appointment on March 14, 2012. (R. at 61-66.) Culbertson's complained of a urinary tract infection. (R. at 61.) Culbertson did not complain of any extremity pain or numbness or any abdominal discomfort. (R. at 61.) Dr. Licup noted that Culbertson suffered from chronic low back pain which began a year previously without any known injury. (R. at 61.) Culbertson said that her low back pain was exacerbated by prolonged sitting, lifting and supine position. (R. at 61.) Culbertson stated that she was able to do housework with limitations. (R. at 61.)

Culbertson complained of feeling fatigued with heart palpitations. (R. at 61.) She also complained of dysuria, joint pain and swelling, dizziness, anxiety and depression. (R. at 61-62.) Dr. Licup noted that Culbertson was 5 feet tall and weighed 163 pounds. (R. 63.) Dr. Licup stated that Culbertson was alert, in no acute distress and well-nourished. (R. at 63.) Dr. Licup noted that Culbertson's heart rate and rhythm was normal, as was her respiratory rhythm and effort and her gait and movement of all extremities. (R. at 63.) Dr. Licup also noted normal vibratory and tactile sensation through Culbertson's legs into her feet. (R. at 64.) Dr. Licup diagnosed Culbertson as suffering from diabetes, hyperlipidemia and lower back pain. (R. at 65.) Dr. Licup also noted that she was referring Culbertson for pain management. (R. at 66.)

Culbertson returned to see Dr. Licup on April 11, 2012, complaining of worsened depression and crying all the time. (R. at 54-60.) Dr. Licup documented that Culbertson denied any abdominal pain or any joint pain or stiffness. (R. at 55.) Nonetheless, Dr. Licup also stated that Culbertson currently suffered from left-sided abdominal pain, joint pain and lower back pain. (R. at 55.) Dr. Licup recommended that Culbertson switch her antidepressant medication from Zoloft to Effexor. (R. at 59.) Culbertson did not want to switch, so Dr. Licup referred her for counseling. (R. at 59.)

Culbertson returned to see Dr. Licup on May 2, 2012, for an initial evaluation of chest pain. (R. 48-53.) Culbertson denied any anxiety, sweating, nausea or vomiting associated with the episodes of chest pain. (R. at 48.) Dr. Licup's examination showed normal heart rate and rhythm, no respiratory distress with normal respiratory rhythm and effort and tenderness on the left third and fourth ribs. (R. at 50.) Dr. Licup diagnosed atypical chest pain, most likely costochondritis. (R. at 53.)

Culbertson returned to Dr. Licup for a follow-up visit on June 13, 2012. (R. at 40-47.) Culbertson complained of continuing chest pain, which was made worse by exercising and improved with resting. (R. at 40.) She said the pain was sharp and squeezing, and she rated the severity of pain as a 5 on a 10-point scale. (R. at 40.) Dr. Licup ordered a cardiac stress test. (R. at 44.)

Culbertson returned to Dr. Licup for a routine follow-up visit for her diabetes on July 2, 2012. (R. at 35-39.) Culbertson returned to Dr. Licup on August 20, 2012, with complaints of developing an "allergic reaction with nausea and

chilling for several days” after treatment at a pain clinic with Opana and baclofen. (R. 30-34.) Culbertson stated that she did not want to return to the pain clinic. (R. at 34.) Dr. Licup told Culbertson that she would not prescribe narcotic pain medicine for her and wrote a prescription for naproxen. (R. at 34.) Dr. Licup urged Culbertson to consider disc surgery if her back pain was severe and was altering her daily functions. (R. at 34.)

Culbertson saw Dr. Licup again on October 3, 2012, complaining of burning, urgency and frequency of urination and fatigue. (R. at 22-29.) She followed up with Dr. Licup again on November 20, 2012. (R. at 15-21.) Dr. Licup noted abnormal findings on thyroid function testing. (R. at 18.)

Culbertson’s attorney also submitted additional medical reports from Dr. Gregory Corradino, M.D., of the East Tennessee Brain & Spine Center, to the Appeals Council. According to these reports, Dr. Corradino saw Culbertson on August 14, 2012. (R. at 7-9.) Culbertson complained of increasing back, left buttock and leg pain over the previous three years. (R. at 7.) On examination, Dr. Corradino noted some mild tenderness of the axial spine and straight leg raise testing reproduced buttock pain at about 60-70 degrees with dorsiflexion stretch. (R. at 9.) Dr. Corradino noted good strength in dorsiflexion and plantar flexion bilaterally. (R. at 9.) Strength testing of Culbertson’s quadriceps, hip flexors and knee extensors all were 5/5. (R. at 9.) Culbertson’s reflexes were 2 and brisk at the knees, left Achilles was 1-2, and right was 2. (R. at 9.) Dr. Corradino noted no clonus, no long-tract signs and a mildly antalgic gait. (R. at 9.)

Dr. Corradino noted that an MRI scan completed at Indian Path Medical

Center showed some degenerative disc disease at the L4-L5 level with a central and right-sided foraminal disc herniation. (R. at 9.) At the L5-S1 level, there was a central and left-sided foraminal disc herniation that may have compromised the left L5 nerve root. (R. at 9.) Dr. Corridino diagnosed Culbertson with a herniated disc with lumbar radiculopathy. (R. at 9.) Dr. Corridino stated that he thought Culbertson's complaints of leg pain were caused by the central and left-sided disc herniation at the L5-S1 level. (R. at 9.) He recommended a left L5-S1 hemilaminectomy and discectomy with decompression. (R. at 9.)

III. Analysis

The Commissioner uses a five-step process in evaluating DIB claims. *See* 20 C.F.R. § 404.1520 (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 her past relevant work; and 5) if not, whether she can perform other work. *See* 20 C.F.R. § 404.1520. 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) (2013).

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. The 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).

Culbertson argues that substantial evidence does not support the ALJ's finding that she was not disabled at any time during the relevant period. (Plaintiff's Memorandum In Support Of Her Motion For Summary Judgment, ("Plaintiff's Brief"), at 2.) In particular, Culbertson argues that substantial evidence does not support the ALJ's finding that she did not suffer from a severe mental impairment during the relevant period. (Plaintiff's Brief at 5-7.) She further argues that the ALJ failed to give proper credence to her testimony and properly assess the effect of pain on her ability to perform substantial gainful activity. (Plaintiff's Brief at 7-8.)

The ALJ found that, during the relevant period, Culbertson suffered from a combination of severe impairments, namely, carpal tunnel syndrome, gastroesophageal reflux disease, obesity, migraine headaches and restless leg syndrome; the ALJ did not find that Culbertson suffered from a severe mental impairment. (R. at 90-92.) Based on my review of the record, I find that substantial evidence supports the ALJ's finding on this issue. While the record documents that Culbertson had a long history of depression and anxiety, there is no evidence that these conditions affected her ability to work during the relevant period from 2003 to 2008. To the contrary, Culbertson continually assured Dr. Kutty that she was able to work and that working helped her symptoms. (R. at 372, 383.) Dr. Kutty's notes contain several mentions of Culbertson's depression and anxiety responding well to medications. (R. at 379, 380, 383.) "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).

Once Dr. Griffin started prescribing Culbertson’s psychological medications in 2003, there is little mention of psychological complaints or mental impairment. The same is true once Culbertson started seeing Dr. Wilson in 2005. There is some mention of the possibility of Culbertson suffering from panic attacks in 2006, but further evaluation of her complaints of chest pain showed that it was reproducible, (R. at 400), and led to a diagnosis of costochondritis. (R. at 405.) Perhaps most importantly, none of her treating physicians placed any limitations on Culbertson’s work-related activities as a result of any mental impairment. Under the Social Security regulations, a “nonsevere” impairment is 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. § 404.1521(a) (2013).

While Lanthorn documented a severe mental impairment placing significant restrictions on Culbertson’s work-related abilities, Lanthorn did not evaluate Culbertson until more than two years after her date last insured. During the relevant period, state psychologists Leizer and Tenison both stated that Culbertson suffered from an affective disorder and anxiety-related disorder, which were not severe. (R. at 451-63, 468-81).

I also find that the ALJ properly analyzed Culbertson’s subjective complaints and that substantial evidence exists to support his findings on this issue. “[P]ain itself can be disabling, and it is incumbent upon the ALJ to evaluate the effect of pain on a claimant’s ability to function.” *Walker v. Bowen*, 889 F.2d 47,

49 (4th Cir. 1989). The determination of whether a claimant is disabled by pain or other subjective symptoms is a two-step process under the Act. *See Craig v. Chater*, 76 F.3d 585, 594-95 (4th Cir. 1996); 20 C.F.R. §§ 404.1529(b), (c), (2013). First, there must be objective medical evidence showing the existence of an impairment that could reasonably be expected to produce the actual pain, in the amount and degree alleged by the claimant. *See Craig*, 76 F.3d at 594-95. Only after the existence of such an impairment is established must the ALJ consider the intensity and persistence of the claimant's pain and the extent to which it affects the ability to work. *See Craig*, 76 F.3d at 594-95. Although a claimant's allegations about pain may not be discredited solely because they are not substantiated by objective evidence of the pain itself or its severity, they need not be accepted to the extent they are inconsistent with the available evidence. *See Craig*, 76 F.3d at 595. Evidence of a claimant's activities as affected by the pain is relevant to the severity of the impairment. *See Craig*, 76 F.3d at 595.

Furthermore, an ALJ's assessment of a claimant's credibility regarding the severity of pain is entitled to great weight when it is supported by the record. *See Shively v. Heckler*, 739 F.2d 987, 989-90 (4th Cir. 1984). “[S]ubjective evidence of pain cannot take precedence over objective medical evidence or the lack thereof.” *Parris v. Heckler*, 733 F.2d 324, 327 (4th Cir. 1984). Protection of a claimant's power to establish the existence of disabling pain even without objective evidence of the pain's severity ensures the claimant only the opportunity to persuade the ALJ; it does not, obviously, ensure a favorable result for the claimant. As in the case of other factual questions, credibility determinations as to a claimant's testimony regarding his pain are for the ALJ to make. *See Shively*, 739 F.2d at 989-90 (affirming ALJ's decision to discredit claimant's testimony as to pain that

was out of proportion with objective evidence because the court was persuaded that ALJ considered the testimony). To hold that an ALJ may not consider the relationship between the objective evidence and the claimant's subjective testimony as to pain would unreasonably restrict the ALJ's ability to meaningfully assess a claimant's testimony.

The ALJ found that, from 2003 to 2008, Culbertson suffered from medically determinable impairments that could reasonably be expected to cause some of her alleged symptoms, but that Culbertson's statements concerning the intensity, persistence and limiting effects of her symptoms were not credible to the extent that they prevented her from performing the full range of light work. (R. at 93-94.) Again, none of Culbertson's treating physicians placed any restrictions on her work-related activities during the relevant period. The only physician to address Culbertson's physical residual functional capacity during the relevant period, Dr. Duckwall, stated that she could perform the full range of medium work. (R. at 482-86.)

Based on this, I find that substantial evidence exists in the record to support the ALJ's finding that Culbertson was not disabled during the relevant period.

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 Culbertson did not suffer from a severe

mental impairment during the relevant period;

2. The ALJ properly considered Culbertson's complaints of pain; and
3. Substantial evidence exists in the record to support the Commissioner's finding that Culbertson was not disabled under the Act and was not entitled to DIB benefits.

RECOMMENDED DISPOSITION

The undersigned recommends that the court deny Culbertson'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 all counsel of record at this time.

DATED: August 11, 2014.

s/ Pamela Meade Sargent

UNITED STATES MAGISTRATE JUDGE