

first applied for SSD benefits in 1979. *See* Record at 108. By notice dated December 7, 1979 that request was denied. *See id.* at 87-88. She took no appeal of that decision. *See id.* at 72-73. This was the end of the matter until August 21, 1991, when a divorce prompted the plaintiff to apply once again for SSD benefits. *See id.* at 73, 118. By notice dated October 23, 1991 the second request was denied on the basis that the medical evidence of record did not demonstrate that she was disabled on or before her date last insured. *See id.* at 89-91. Again, the plaintiff did not appeal the denial. *See id.* at 13. Nonetheless, on June 4, 1992 she filed a third application for SSD benefits. *See id.* at 118. By notice dated August 1, 1992 the third application was denied on *res judicata* grounds. *See id.* at 92-93. The plaintiff requested reconsideration, which was denied on or about January 27, 1993, again on the basis of *res judicata*. *See id.* at 95. The plaintiff took no further appeal. *See id.* at 13.

Some years elapsed before, on April 3, 2002, the plaintiff (represented this time by her current counsel) tried again, filing her fourth and current application for SSD benefits. *See id.* at 13, 96, 145-50. This application, too, was denied initially and on reconsideration, following which the plaintiff requested a hearing before an administrative law judge. *See id.* at 99-104. On September 19, 2002 an administrative law judge rendered a decision dismissing her hearing request on *res judicata* grounds. *See id.* at 85-86. The plaintiff appealed the dismissal to the Appeals Council. *See id.* at 107. On November 22, 2002, the Appeals Council vacated the order of dismissal and remanded the case for further proceedings on the basis that the commissioner's musculoskeletal listings had been revised effective February 19, 2002, creating "a new adjudicative standard" and necessitating a "substantive decision under the regulations[.]" *Id.* at 127. Per this directive, a hearing was held before an administrative law judge on February 4, 2003, *see id.* at 23, who rendered a decision on the merits on July 24, 2003, *see id.* at 13-20.

In accordance with the commissioner’s sequential evaluation process, 20 C.F.R. § 404.1520, *Goodermote v. Secretary of Health & Human Servs.*, 690 F.2d 5, 6 (1st Cir. 1982), the administrative law judge found, in relevant part, that the plaintiff had acquired sufficient quarters of coverage to remain insured only through December 31, 1984, Finding 1, Record at 18; that she had multiple sclerosis, an impairment that was severe but did not meet or equal any listed in Appendix 1 to Subpart P, 20 C.F.R. § 404 (the “Listings”), Findings 3-4, *id.* at 19; that she retained the residual functional capacity (“RFC”), before the close of December 1984, to perform work not requiring heavy lifting and carrying, standing more than two to four hours in a workday, frequently walking on uneven ground or climbing or balancing more than occasionally, or entailing concentrated exposure to heat, Finding 7, *id.*; that considering her age (“younger individual between the ages of 18 and 44”), education (high school or equivalent), work experience (unskilled) and RFC for sedentary work, Rule 201.27 of Table 1, Appendix 2 to Subpart P, 20 C.F.R. § 404 (the “Grid”), directed a finding of “not disabled,” Findings 9-13, *id.*; and she therefore was not under a disability at any time through the date of decision, Finding 14, *id.*² The Appeals Council declined to review the decision, *id.* at 5-7, making it the final determination of the commissioner, 20 C.F.R. § 404.981; *Dupuis v. Secretary of Health & Human Servs.*, 869 F.2d 622, 623 (1st Cir. 1989).

The standard of review of the commissioner’s decision is whether the determination made is supported by substantial evidence. 42 U.S.C. § 405(g); *Manso-Pizarro v. Secretary of Health & Human Servs.*, 76 F.3d 15, 16 (1st Cir. 1996). In other words, the determination must be supported by such relevant evidence as a reasonable mind might accept as adequate to support the conclusion drawn.

² Presumably, the administrative law judge meant to say that the plaintiff was not under a disability at any time through her date last insured (December 31, 1984).

Richardson v. Perales, 402 U.S. 389, 401 (1971); *Rodriguez v. Secretary of Health & Human Servs.*, 647 F.2d 218, 222 (1st Cir. 1981).

The administrative law judge reached Step 5 of the sequential process, at which stage the burden of proof shifts to the commissioner to show that a claimant can perform work other than his past relevant work. 20 C.F.R. § 404.1520(f); *Bowen v. Yuckert*, 482 U.S. 137, 146 n.5 (1987); *Goodermote*, 690 F.2d at 7. The record must contain positive evidence in support of the commissioner’s findings regarding the plaintiff’s RFC to perform such other work. *Rosado v. Secretary of Health & Human Servs.*, 807 F.2d 292, 294 (1st Cir. 1986).

The plaintiff attacks the July 24, 2003 decision on multiple grounds that she organizes under six broad headings: (i) treating-physician evidence, (ii) onset date, (iii) analysis of subjective symptoms, (iv) RFC, (v) the vocational expert and the Grid and (vi) credibility analysis. *See generally* Plaintiff’s Itemized Statement of Specific Errors (“Statement of Errors”) (Docket No. 8).³ Under the first broad heading, she argues, *inter alia*, that the administrative law judge erred in basing his RFC finding on the report of a non-examining consultant that cannot, under the circumstances of this case, constitute substantial evidence. *See id.* at 16. I agree. Inasmuch as I conclude that this error alone warrants remand, I do not reach the balance of the plaintiff’s points except insofar as to comment, for the guidance of the parties on remand, that (i) I concur that the administrative law judge committed error in failing to afford any consideration whatsoever to newly submitted retrospective opinions of two treating physicians – an error that should be rectified on

³ The plaintiff notes that she challenges not only the administrative law judge’s denial of her current application but also his refusal to reopen her prior claims. *See* Statement of Errors at 2 n.1. However, she observes that she focuses on the merits of the current application inasmuch as any error in failing to reopen the prior claims would be moot if she could not prove entitlement to benefits on the merits of the current claim. *See id.* Accordingly, I likewise focus on the merits of the current application.

remand, and (ii) inasmuch as there is no dispute that the plaintiff currently is disabled, Social Security Ruling 83-20, governing onset date, should be applied on remand.

I. Discussion

On the basis of a change in the law, the Appeals Council essentially granted the plaintiff a second bite at the apple with respect to her claim to have been disabled on or before December 31, 1984. She took advantage of that opportunity to submit new evidence, including contemporaneous Martin's Point Health Care Center ("Martin's Point") records that had not previously been obtained by or supplied to the commissioner, *see* Record at 4 (describing Exhibit 7F), 25, 29-31, 270-312,⁴ and retrospective opinions from two current treating neurologists, *see id.* at 330-31 (note dated August 30, 2002 by Bernard P. Vigna, Jr., M.D., of Coastal Neurological Services), 343 (note dated October 21, 2002 by T. Edward Collins, D.O., of Maine Neurology). Nonetheless, in determining the plaintiff's RFC as of her date last insured the administrative law judge relied upon the sole preexisting RFC assessment of record, completed almost a decade earlier (on June 19, 1992) by non-examining Disability Determination Services ("DDS") physician Lawrence P. Johnson, M.D. *See id.* at 16-17, 262-69.

As the plaintiff observes, *see* Statement of Errors at 16, "the amount of weight that can properly be given the conclusions of non-testifying, non-examining physicians will vary with the circumstances, including the nature of the illness and the information provided the expert[.]" *Rose v. Shalala*, 34 F.3d 13, 18 (1st Cir. 1994) (citations and internal quotation marks omitted). "In some cases, written reports submitted by non-testifying, non-examining physicians cannot alone constitute substantial evidence, although this is not an

⁴ Exhibit 7F, which the commissioner lists as containing Martin's Point records, include some records bearing the title, "Coastal Health Service." *See id.* at 4, 310. For ease of reference, I shall refer to any records contained within Exhibit 7F (*continued on next page*)

ironclad rule.” *Rose*, 34 F.3d at 18 (citations omitted). The plaintiff posits that in the circumstances, Dr. Johnson’s report cannot constitute substantial evidence of her RFC. *See* Statement of Errors at 16. I agree.

Based on the record as it stood in 1992, Dr. Johnson found the plaintiff capable as of her date last insured of, *inter alia*, lifting up to fifty pounds occasionally, up to twenty-five pounds frequently, standing and/or walking for two to four hours in an eight-hour workday and sitting with normal breaks for a total of about six hours in an eight-hour workday. *See* Record at 263. He also found her unlimited in ability to push and/or pull (including operation of hand/and or foot controls) and free of any manipulative or visual limitations. *See id.* at 263, 265. He noted that the plaintiff’s problems with multiple sclerosis first had surfaced in 1974, observing: “Since then she has had several exacerbations which basically affect her L.E.s [lower extremities] + cause a wide based gait + weakness. During remissions her exam is basically wnl [within normal limits] + disease is considered ‘benign.’ She started using a cane in 1986.” *Id.* at 269.

The administrative law judge concluded, in relevant part:

The State agency medical expert’s opinion in Exhibit 6F is consistent with the findings of treating physicians and the subjective allegations that [the plaintiff] reported to them. From 1978 to 1981, she has had exacerbations that primarily involved her gait, but also included some subjective paresthesias in her fingers. She didn’t require any medication for multiple sclerosis from 1980 to 1985. She did not require a cane for assistance walking until 1986. No physician advised her not to work prior [to] 1985. The exacerbations that she had before 1985 seemed to clear quickly, especially when Prednisone was given. The State agency assessment of residual functional capacity took into consideration her symptoms relating to her gait and station.

Id. at 17. He found the plaintiff capable of performing the full range of sedentary work as of her date last insured. *See id.* at 18.

as “Martin’s Point” records.

A central premise of Dr. Johnson's assessment, subscribed to by the administrative law judge, was that during the period prior to her date last insured the plaintiff essentially was symptom-free during her then-lengthy periods of remission in her disease. The plaintiff suggests that the newly discovered evidence, particularly a July 20, 1984 progress note of Marcelle Pick, R.N.C., calls this notion into question. *See* Statement of Errors at 15 ("The [July 20, 1984] examination outlined the everyday problems she was having due to the progression of her disease, not due to an exacerbation.").

At oral argument, counsel for the commissioner pointed out that a nurse or nurse practitioner, such as Pick, is not an "acceptable medical source," diminishing the weight to which her report is entitled, and in any event the new evidence is cumulative in the sense that it covers the same time period as medical records to which the DDS reviewer did have access.

It is indeed true that a nurse or nurse practitioner is not among practitioners recognized as an "acceptable medical source[]" to establish whether [a claimant has] a medically determinable impairment(s)[.]" 20 C.F.R. § 404.1513(a). Moreover, while an administrative law judge "may" consider evidence from non-acceptable medical sources (such as a nurse practitioner) in assessing RFC, *see id.* § 404.1513(d), no particular level of deference is due such evidence, *compare id.* § 404.1527(a)(2) & (d) (detailing how commissioner must weigh "medical opinions," defined as opinions from "acceptable medical sources").

Nonetheless, the question of the weight to which a record such as Pick's is entitled is distinguishable from the question whether a DDS non-examining reviewer's RFC assessment can stand as substantial evidence in the absence of consideration of a complete medical record. Inasmuch as records such as Pick's clearly "may" be considered in connection with RFC, the critical question, in my view, is

whether the Martin's Point records are merely cumulative (and thus their absence from the palette of evidence presented to Dr. Johnson harmless). I conclude that they are not.

During what appears to have been a thorough physical examination by Pick on July 20, 1984, the plaintiff did not claim to be then experiencing a relapse, or exacerbation; rather, she stated that her last "severe relapse" had been in 1979 with "none since then." *See* Record at 310. Nonetheless, she told Pick that she continued to have numbness in her hands, discomfort and severe weakness in her right hip and a limp, and that she became very weak and could not shop or do housework for any length of time. *See id.* On examination, Pick noted "[p]oor coordination, difficulty with walking in a straight line" and a "right leg lag." *Id.* Pick's report concluded with the following assessment and plan:

ASSESSMENT: 1. Long history of MS. 2. Increased caffeine consumption. 3. Right hip discomfort and noticed to have a right limp. 4. UA [urinalysis] indicated UTI [urinary tract infection]. 5. Periodic depression regarding MS.

PLAN: 1. Will talk with neurologist about need for further work-up for the right hip limb. 2. Suggested she decrease caffeine consumption. 3. Begin Bactrim 1 tab bid x 14 days, to return in two weeks for discussion of the above findings and 4. suggests she might want to see Bill Harrison. Will do CBC, UA, Chem-22, Pap and EKG today.

Id. at 311. The Martin's Point records contain a brief followup note by Pick dated August 3, 1984, stating:

S: [Plaintiff] comes in today for a recheck of her PE [physical examination]. All lab work was within normal limits. She was treated on her last visit for a UTI and will recheck her urine today.

O: Deferred.

A: Normal PE with normal lab results except for needing follow-up of UTI.

P: UA today; will also repeat her liver function today as she did have a mildly elevated bilirubin.

Id. at 312. The administrative law judge evidently construed the August 3, 1984 followup note as reflecting that the plaintiff was then symptom-free, observing:

On July 20, 1984, nurse practitioner Marcelle Pick of Coastal Health Service found that

the claimant had poor coordination and difficulty walking in a straight line. However, on August 3, 1984 she found that the claimant had a normal physical examination. She did not return to Coastal Health Service until November 1985.

Id. at 16. While the matter is not free from doubt, I am inclined to agree with the plaintiff that the administrative law judge misread the August 3, 1984 office note given that the import of the visit was to follow up on lab work and check whether a urinary tract infection had cleared up: “The short note . . . cannot be fairly read to indicate that [the plaintiff] was suddenly devoid of her baseline MS symptoms, as the ALJ’s wording suggests.” Statement of Errors at 15.⁵

It is noteworthy, too, that the Martin’s Point records reflect that when the plaintiff did next return to that facility for a routine physical examination on November 15, 1985, less than a year after the expiration of her date last insured, she reported that she was then experiencing an exacerbation of her disease, which she described as a worsening, rather than an onset, of symptoms:

Her chief complaint today is worsening of her symptoms she has with multiple sclerosis. MS was diagnosed on a clinical basis in 1974. Problems she has had include bilateral leg numbness, cerebellar dysfunction, hand tingling, diplopia, vertigo and diminished bladder and bowel control. . . . She required treatment with Prednisone on one occasion in 1979 when she had bilateral leg numbness. In the past several wks she has had more problems with balance and bilateral leg weakness right greater than left and left leg parasthesias. Associated with this she has had worsening of her bilateral hand numbness and a mild nagging headache. She has not had any diplopia or decreased vision or vertigo with this episode.

Record at 308.

⁵ At oral argument, counsel for the commissioner contended that inasmuch as the followup note reasonably can be construed either way – as reflecting a normal physical examination in all respects or, alternatively, as reflecting only normal laboratory results – the administrative law judge’s finding cannot be disturbed under the substantial-evidence standard. “The ALJ’s findings of fact are conclusive when supported by substantial evidence, but are not conclusive when derived by . . . judging matters entrusted to experts.” *Nguyen v. Chater*, 172 F.3d 31, 35 (1st Cir. 1999) (citations omitted). The seeming ambiguity of the Pick followup note underscores the need to have presented the Martin’s Point records to a medical advisor.

Prior to the unearthing of the Martin’s Point evidence, the contemporaneous medical evidence did indeed tend to suggest that the plaintiff, even by her own self-report, had enjoyed essentially symptom-free living during those periods when her disease was in remission from 1979 to 1984. *See, e.g., id.* at 229 (Neurologic Re-evaluation by Walter C. Allan, M.D., dated November 7, 1985, stating, *inter alia*: “I have not seen [the plaintiff] since 1981. She has been doing quite well, until this September when she had an exacerbation. She had had some mild residual feelings of stiffness in the left leg, and had some decreased vision in the right eye, but was otherwise excellent.”). Thus, the Martin’s Point records are, in my view, sufficiently material that reliance on an RFC assessment completed by a non-examining physician who did not have their benefit is reversible error. While one can theorize that Dr. Johnson might not have revised his RFC opinion even with the benefit of the Martin’s Point records, one cannot be confident that they would have had no impact.⁶

While this error alone justifies reversal, and thus I need consider none of the plaintiff’s other points, I comment briefly, for the benefit of the parties on remand, on two of those contentions:

1. Improper Treatment of Treating Physicians. The plaintiff posits that the administrative law judge erred in omitting any mention whatsoever of the retrospective opinions of Drs. Vigna and Collins, which she asserts should have been accorded controlling weight or, at the least, deference. *See* Statement of Errors at 17-18. No “special significance” is attached even to the opinions of treating physicians when (as here) they concern the ultimate question of disability – an issue reserved to the commissioner. *See* 20

⁶To the extent there is any doubt, I resolve it in favor of the plaintiff given the retrospective opinions of two of her current treating neurologists, Drs. Vigna and Collins, based in part on review of Dr. Allan’s medical records spanning the period from 1978 through 1987, that she has been “significantly disabled” from her multiple sclerosis since 1981. *See* Record at 331, 343. Dr. Johnson did not, of course, have the benefit of these views, either, when he completed his RFC assessment.

C.F.R. § 404.1527(e)(1)-(3).⁷ Nonetheless, the commissioner must “always give good reasons in [her] notice of determination or decision for the weight we give your treating source’s opinion.” *Id.* § 404.1527(d)(2). The administrative law judge failed to do so, simply ignoring the Vigna and Collins opinions. That error should be rectified on remand.⁸

2. Failure To Apply SSR 83-20: The plaintiff asserts that the administrative law judge committed reversible error in failing to apply Social Security Ruling 83-20. *See* Statement of Errors at 18-20. Technically, Ruling 83-20 pertains to adjudication of the onset date of disability only when a claimant has been determined to be disabled. *See* Social Security Ruling 83-20, reprinted in *West’s Social Security Reporting Service Rulings 1983-1991* (“SSR 83-20”), at 49 (“In addition to determining that an individual is disabled, the decisionmaker must also establish the onset date of disability.”); *see also, e.g., Beasich v. Commissioner of Soc. Sec.*, 66 Fed. Appx. 419, 432 (3d Cir. 2003) (“Here there was no dispute that, in the context of a separate application for SSI benefits, Beasich was determined to have been ‘disabled’ as of August 1, 1996, by his psychiatric condition that was the result of his head injury in 1981. In view of that earlier SSI disability finding, the task of the ALJ in the context here was to determine onset – *i.e.*, when

⁷ At oral argument, counsel for the commissioner declined to concede that Drs. Vigna and Collins even qualify as “treating physicians” given that they did not treat the plaintiff during the relevant period. Although I find no First Circuit caselaw on point, the language of pertinent regulations suggests that lack of a treatment relationship during the relevant period would go to the weight of a retrospective opinion, rather than disqualifying a practitioner as a treating source. *See* 20 C.F.R. §§ 404.1502 (“*Treating source* means your own physician, psychologist, or other acceptable medical source who provides you, or has provided you, with medical treatment or evaluation and who has, or has had, an ongoing treatment relationship with you.”) (emphasis in original), 404.1527(d) (describing factors used to weigh medical opinions, including those from treating sources); *see also, e.g., Klett v. Barnhart*, 303 F. Supp.2d 477, 484 (S.D.N.Y. 2004) (“An ALJ should attribute significant (though not controlling) weight to a retrospective diagnosis from a physician who is currently treating a claimant but who was not treating the claimant during the relevant time period. As the ALJ noted, a retrospective diagnosis from a physician, particularly one who was not the claimant’s treating physician during the relevant time period, may carry less weight if the diagnosis is inconsistent with other substantial evidence in the record.”) (citing, *inter alia*, 20 C.F.R. § 404.1527(d)(4)) (other citations omitted).

⁸ I mean to express no opinion as to the weight that the Vigna and Collins opinions should be accorded on remand. I merely note that the commissioner is obliged to provide “good reasons” for the weight given.

Beasich's impairments first became disabling. An earlier onset date assessment is mandated when a claimant already has been found disabled and alleges an earlier disability onset date.") (footnote omitted); *Key v. Callahan*, 109 F.3d 270, 274 (6th Cir.1997) ("Since there was no finding that the claimant is disabled as a result of his mental impairment or any other impairments or combination thereof, no inquiry into onset date is required."). Although no such official determination of disability has been made in this case, counsel for the commissioner acknowledged at oral argument that the plaintiff is, in fact, currently disabled.⁹ Accordingly, on remand, it is appropriate for the commissioner to apply SSR 83-20 to determine the plaintiff's onset date of disability.

II. Conclusion

For the foregoing reasons, I recommend that the decision of the commissioner be **VACATED** and the case **REMANDED** for proceedings not inconsistent herewith.

NOTICE

A party may file objections to those specified portions of a magistrate judge's report or proposed findings or recommended decisions entered pursuant to 28 U.S.C. § 636(b)(1)(B) for which de novo review by the district court is sought, together with a supporting memorandum, within ten (10) days after being served with a copy thereof. A responsive memorandum shall be filed within ten (10) days after the filing of the objection.

Failure to file a timely objection shall constitute a waiver of the right to de novo review by the district court and to appeal the district court's order.

⁹This concession was made in the context of counsel's argument that even applying Ruling 83-20, the outcome would be the same given that (i) the contemporaneous medical evidence does not support a finding of disability prior to the plaintiff's date last insured, and (ii) pursuant to Ruling 83-20, onset date cannot be inconsistent with such evidence. Nonetheless, inasmuch as remand is appropriate on other grounds and current disability is conceded, the ruling should be applied.

Dated this 26th day of August, 2004.

/s/ David M. Cohen
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United States Magistrate Judge

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