

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
NORTHERN DIVISION

ROY JAMES KINSLOW,)
)
 Plaintiff,)
)
 v.) No. 2:02 CV 37 DDN
)
 JO ANNE B. BARNHART,)
 Commissioner of)
 Social Security,)
)
 Defendant.)

MEMORANDUM

This action is before the court for judicial review of the final decision of the defendant Commissioner of Social Security denying the application of plaintiff Roy James Kinslow for supplemental security income (SSI) benefits based on disability under Title XVI of the Social Security Act (the Act), 42 U.S.C. §§ 1381, et seq. The parties consented to the exercise of plenary jurisdiction by the undersigned United States Magistrate Judge pursuant to 28 U.S.C. § 636(c). Oral argument was heard on August 1, 2003.

I. BACKGROUND

A. The evidence

On December 6, 1999, plaintiff applied for SSI benefits, alleging that in November 1998 he became disabled because of poor eyesight, joint pain, arthritis, and disc disease, which resulted in the inability to stand and bend, limited movement, and loss of feeling in his right leg.¹ His application materials indicated that he was born in 1948, had a twelfth grade education, and in

¹On three previous occasions, the most recent being January 6, 1999, plaintiff had also applied for, and was denied, SSI benefits.

the previous fifteen years had held several jobs, including that of a building security guard. (Tr. 224, 224, 226, 248-49.)

The work-history report plaintiff completed (Ex. B-3E) states that he had performed the security-guard job for six months in 1995 and that he performed the job for nine hours per day, seven days per week. He described the work as watching a building for burglary. He left blank portions of the report that asked how many total hours each day he walked, climbed, kneeled, crouched, crawled, and handled, grabbed or grasped objects. He put "x" marks in the blanks where he was asked how many total hours each day he stood, sat, and wrote, typed or handled small objects. In response to questions regarding the heaviest weight he lifted and the weight he frequently lifted, plaintiff put "x" marks next to the answer "Other," but did not write in any amount. (Tr. 249, 253.)

On January 20, 2000, Seyed A. Hejazi, M.D., saw plaintiff for complaints of back pain. Upon physical examination, there was no gross deformity or signs of joint inflammation, mild tenderness of the lumbar spine, and intact range of motion in all joints but for the right hip, which was attributed to lower back pain, and negative straight leg raising on both sides. He noted that plaintiff had mild muscle atrophy of his right calf and right foot muscles, no muscle spasms or tenderness, and a decreased vibration sensation in the legs. Additionally, he noted that plaintiff had nystagmus,² which was horizontal either with or without eye movements. He observed that plaintiff walked without assistance but limped on his right leg and that he was able to walk on his toes and heels. Plaintiff's medications were Tylenol, Relefen, and Amitriptyline. Dr. Hejazi indicated that he could not evaluate in terms of duration plaintiff's limitations with walking, sitting,

²"[N]ystagmus" is a "rhythmical oscillation of the eyeballs, either pendular or jerky." Stedman's Medical Dictionary 1074 (25th ed. 1990).

standing, and lifting objects. He acknowledged that an x-ray of plaintiff's lumbar spine showed "degenerative disc disease of L5 to S1" and that a CT scan additionally showed "annular disc bulging with a slight asymmetry toward the left at L4 and L5." Finally, he assessed plaintiff with, inter alia, degenerative joint disease of the lumbar spine with a bulging annular disc and recurrent headaches.³ (Tr. 349-52.)

On March 15, 2000, George Kerkemeyer, M.D., ordered an MRI of plaintiff's lumbar spine to evaluate his back pain and radiculopathy.⁴ The MRI showed degenerative disc disease at L5-S1 with right posterolateral herniation and impingement of the right S1 nerve root. Dr. Kerkemeyer noted on April 5 that plaintiff was still complaining of back problems. He referred plaintiff to Tria Wilhite, M.D, for epidural steroid injections into his back. Plaintiff reported to Dr. Kerkemeyer on May 3 that he had received one injection but his symptoms gradually recurred and returned to their prior level. Dr. Kerkemeyer noted that plaintiff did yard work for small amounts of time and took breaks when his symptoms occurred. On July 7 plaintiff returned to Dr. Kerkemeyer, complaining of back and right leg pain. Dr. Kerkemeyer recommended surgical intervention, but plaintiff was not willing to proceed because he was caring for his terminally ill girlfriend. (Tr. 361-63, 370.)

On October 5, 2000, the Administrative Law Judge (ALJ) conducted a hearing at which plaintiff testified to the following. His eye condition caused constant eye movement. He worked as a night security guard and last worked in November 1998. As a

³Dr. Hejazi also assessed plaintiff with chest pain. Plaintiff subsequently underwent myocardial examinations, the results of which appeared normal. (Tr. 352, 375-76.)

⁴"[R]adiculopathy" means "[d]isease of the spinal nerve roots and nerves." Stedman's Medical Dictionary 1308 (25th ed. 1990).

security guard he walked the halls in three buildings that were each three stories high and made sure people were not "hanging around" in the hallways. Because of inabilities to stand or sit for long periods or lift anything of consequence, he could no longer work. He lived with his terminally ill girlfriend, who could no longer get up on her own. Her legs once gave out as he was helping her; he ended up carrying most of her weight, which caused him a great deal of pain for two or three days. He felt reluctant to undergo back surgery because of the risk involved. Regarding daily activities, plaintiff swept and mopped but had to rest after doing each room. He mowed his tiny front yard with a push mower. He shopped for groceries, did laundry, used a cane, and fished for catfish from the shore, where he could sit on a chair and wait. He was beginning to have trouble bathing because he lacked flexibility. His pain sometimes caused him to lose track of conversations. When he did simple movements it felt as if a piece of broken glass was being dragged across his back. Plaintiff had very little feeling in his right foot, which had caused him to fall. He used to walk a mile a day but could no longer do so. He was born with his visual problem, but it had worsened a bit with age. The ALJ stated that he would await updated treatment notes before making a decision. (Tr. 35, 37, 40-41, 43-48, 51-52, 55, 57-59.)

On January 24, 2001, the state disability determinations agency referred plaintiff to Brett D. Hosley, D.O., for a consultative examination. His prescription medications were Relefen, Ultram,⁵ and Amitriptyline. Dr Hosley indicated that plaintiff had no tenderness to palpation of the arm or leg muscles or joints. He had a full range of joint motion. Straight leg

⁵Ultram "is indicated for the management of moderate to moderately severe pain." Physicians' Desk Reference 2399 (55th ed. 2001).

raising testing was negative. Plaintiff had a decreased range of motion in the cervical and thoracic spine but no tenderness to palpation in those regions. In the lumbosacral spine he had a significantly decreased range of motion, with complaints of mild pain. No evidence of swelling or change in color or skin temperature was seen. There was mild discomfort to palpation throughout the lumbosacral spine. Plaintiff's vision was 20/70 with correction. He had bilateral nystagmus. (Tr. 391-92.)

Next, Dr. Hosley noted that plaintiff had normal power in his arms and legs, with the exception that testing of plaintiff's right peroneus longus muscle (in the lower leg) showed "questionable mild weakness at 5-/5." The doctor also noted that plaintiff "at times appeared to give good resistance, but at other times had some mild giveaway pattern." As to sensory examination, Dr. Hosley wrote that pinprick testing was "not consistent on repeat testing." He described plaintiff's gait as slow but steady and noted a slight limp to the right, which plaintiff used to keep his back from hurting. Plaintiff was able to walk unassisted and to perform toe and heel walking, but he complained of increased back pain when maneuvering. (Tr. 393.)

Dr. Hosley opined that plaintiff had a chronic history of intermittent low back pain, probably related to spondylitic⁶ changes and previous activities, and that some of his pain could be related to a herniated disk at L5-S1, as documented by MRI scanning. He did not believe, however, that this explained all of plaintiff's low back symptomatology. Dr. Hosley also opined that plaintiff had sensory changes and some discomfort that would be consistent with the L5-S1 nerve root distributions and that the majority of his symptoms were more consistent with L5 nerve root distribution although some area could be related to the S1 nerve

⁶"[S]pondylitis" is "[i]nflammation of one or more of the vertebrae." Stedman's Medical Dictionary 1456 (25th ed. 1990).

root. He was unsure whether plaintiff would be a candidate for surgery. Finally, he stated that, based on the neurologic examination, plaintiff had "relatively mild findings," which were primarily in the form of sensory disturbances in the right leg. (Tr. 393-94.)

On January 29, 2001, Robert R. Conway, M.D., examined plaintiff on referral from Dr. Kerkemeyer. Examination revealed moderately decreased lumbar range of motion, negative straight leg raising, and the ability to walk on the heels and toes with some difficulty. Dr. Conway acknowledged the possibility of a right lumbar radiculopathy in the past but described plaintiff's symptoms as "certainly atypical." The doctor saw no evidence of lumbar radiculopathy and thought physical therapy, as opposed to surgery, would benefit plaintiff. During a March 5 follow-up visit, Dr. Conway noted that plaintiff reported radiating pain down the leg, but overall plaintiff stated it had been decreasing and he was not having as much pain at night. Dr. Conway also noted that plaintiff, who had been participating in physical therapy, was improving in flexibility and could tolerate ten minutes on the treadmill at one mile per hour. (Tr. 397-98.)

Reuben P. Morris, Jr., M.D., who performed a neurosurgery consultative examination of plaintiff on April 18, 2001, on referral from Dr. Kerkemeyer, wrote the following. Examination revealed significant resting nystagmus, normal strength in the legs and arms, except for slight weakness of the right biceps, heel and toe walking carried out with minimal difficulty, no real lumbar tenderness, and no sciatic notch or sacroiliac joint tenderness. Straight leg raising on the right caused some minimal back pain. Likewise, on the left straight leg raising abruptly brought about some low back pain and sensation. Simultaneous hip and knee flexion caused slight back pain on the right side. A review of a March 2000 MRI showed normal alignment with evidence of desiccation

of the L5-S1 disk with posterior bulging of this disk with minimal right herniation. October 2000 lumbar x-rays showed narrowing of the L5-S1 disk space with marginal osteophytosis.⁷ Dr. Morris's diagnostic impression was chronic low back pain due to lumbar disk degeneration, with no clinical evidence of sciatica or significant lumbar radiculopathy. He wanted plaintiff to have a repeat lumbar MRI. (Tr. 401-02.)

On April 27, 2001, plaintiff had another MRI. A radiologist interpreted the results as showing mild focal posterior disk bulging or herniation at the lumbosacral level on the right. This caused mild posterior displacement of the right S1 nerve root, and mild spinal stenosis at the L4-5 level due to degenerative changes. (Tr. 404.)

Plaintiff returned on May 7, 2001, to Dr. Morris who reviewed the MRI. Dr. Morris opined that, given the longevity of plaintiff's symptoms, the lack of significant tension signs, the lack of a compatible neurologic deficit, it was doubtful that plaintiff would improve significantly with a diskectomy.

On June 1, 2001, Dr. Morris completed a form regarding plaintiff's ability to do work-related activities. He opined that plaintiff could lift and carry twenty pounds occasionally; could lift and carry less than ten pounds frequently; could stand and walk about four hours during an eight-hour workday, with normal breaks; could sit about four hours during an eight-hour workday, with normal breaks; and periodically needed to alternate sitting, standing, and walking. He also indicated that plaintiff could sit for twenty to thirty minutes before changing position, could stand for thirty to forty-five minutes before doing so, and would have to walk around for ten to fifteen minutes every forty-five to sixty minutes. As to postural activities, Dr. Morris indicated that

⁷An "osteophyte" is "a bony outgrowth or protuberance." Id. at 1110.

plaintiff could never twist, stoop, or crouch; could frequently climb stairs; and could rarely climb ladders. Dr. Morris referred to plaintiff's symptoms of pain as the basis for the doctor's findings. He concluded "that this data represents an estimate only." (Tr. 377-78, 406.)

On February 6, 2001, plaintiff underwent a vision examination. His corrected vision scores, which also represented his best possible correction, were 20/60 in his right eye, 20/70 in his right eye, and 20/60 combined. (Tr. 286.)

On March 14, 2001, the ALJ asked Dr. Hosley to complete a "medical source statement on ability to do work-related activities (physical)." The doctor responded that records had already been sent. (Tr. 286-89.)

On August 6, 2001, a vocational expert (VE) responded to interrogatories, which included assumptions equivalent to the limitations set forth by Dr. Morris on May 7, 2001, and added restrictions of waist-high work, avoidance of work requiring above-the-shoulder use of both arms, no jobs requiring fine visual detail, avoidance of concentrated exposures to extreme cold, and absence from work about one day a month. The VE indicated that an individual with such limitations could do the security-guard work as plaintiff had described the job in "Exhibit 3BE." The VE also opined that a significant number of jobs did not exist that a person of plaintiff's age, work experience, and limitations assumed could do, because most unskilled work did not allow the worker to change position from sitting and standing and to walk around. (Tr. 293-94, 297-98.)

On May 7, 2002, Dr. Morris reported to Dr. Kerkemeyer that plaintiff was continuing to have back and right leg pain; the MRI showed a small herniation of the L5-S1 disk to the right, abutting and possibly slightly displacing the right S1 nerve root. It was Dr. Morris's opinion that, due to the longevity of plaintiff's

symptoms, the lack of significant tension signs, and the lack of a compatible neurologic deficit, surgery would not improve plaintiff's condition. Dr. Morris recommended that plaintiff start a walking program. (Tr. 406.)

B. The ALJ's decision

Initially, the ALJ noted that, by alleging a disability onset date prior to December 1999, plaintiff was requesting the reopening of his prior applications. Because the 1994 application was not determined by fraud or similar fault, and because neither new or material evidence nor similar good cause was submitted sufficient to reopen the 1997 or January 1999 applications, the ALJ determined that December 1999, the last time plaintiff engaged in substantial gainful activity, was the earliest he could be eligible for payments. (Tr. 17, 21.)

The ALJ found that plaintiff had severe impairments of degenerative joint disease, degenerative disc disk, right shoulder bursitis, and nystagmus but no impairment or combination of impairments listed in, or medically equal to, one Appendix 1, Subpart P, Regulation No. 4.

The ALJ gave several reasons for finding that plaintiff was not fully credible: (1) the objective medical evidence failed to support plaintiff's allegations about his physical limitations; the x-rays, CT scans, and MRIs did not reveal an abnormality that would be expected to limit plaintiff as severely as alleged; (2) Dr. Hosley noted that plaintiff had an inconsistent sensation examination; (3) plaintiff did not list medications indicative of the severity of the symptoms alleged; (4) Dr. Conway noted plaintiff had some improvement with physical therapy; and (5) plaintiff's daily activities contradicted his allegations about his limitations. (Tr. 19-21.)

Next, the ALJ determined that plaintiff had the following residual functional capacity (RFC): he could lift twenty pounds occasionally and lesser weights progressively more frequently; with normal breaks he could stand or sit for up to six hours of an eight-hour workday; he required work space at about waist high; he needed to avoid work requiring use of his arms above shoulder level or repetitive bending; and he was restricted from jobs requiring visual detail. This RFC, the ALJ found, reflected an ability to perform a range of light work. (Tr. 21-22.)

The ALJ explained that Dr. Morris's opinion on plaintiff's limitations warranted neither controlling weight nor much deference because (1) Dr. Morris only estimated plaintiff's abilities, (2) his opinion was not well supported by medically acceptable clinical and laboratory diagnostic techniques, (3) it was inconsistent with other substantial medical evidence in the case record, and (4) it was inconsistent with his own treatment recommendations of analgesic medications and a walking program. Plaintiff's past relevant work as an unarmed security guard/night watchman, the ALJ found, did not require the performance of work-related activities precluded by the limitations the ALJ had specified. Thus, the ALJ concluded plaintiff was not disabled. (Tr. 20-22.)

The Appeals Council denied plaintiff's request for review of the ALJ's decision. Thus, the ALJ's decision became the final decision subject to this judicial review.

C. Plaintiff's arguments

In his brief (Doc. 17), plaintiff argues that substantial evidence does not support the ALJ's determination, because the ALJ (1) did not accord appropriate weight or deference to the opinion of plaintiff's treating physician, Dr. Morris, even though the doctor's opinion is not inconsistent with other substantial medical evidence, and (2) did not provide sufficient analysis and basis for

finding that plaintiff was not fully credible. Plaintiff also argues that, if the ALJ believed Dr. Morris's opinion was incorrect, the ALJ should have sought an opinion from plaintiff's treating physicians or ordered consultative examinations to assess his RFC. In addition, he argues that, in light of the VE's opinion that only plaintiff's security skills would transfer, and only to very similar security guard jobs, the transferability of his skills as a security guard is not supported by substantial evidence.

II. DISCUSSION

A. General legal framework

The court's role on review is to determine whether the Commissioner's findings are supported by substantial evidence in the record as a whole. See Krogmeier v. Barnhart, 294 F.3d 1019, 1022 (8th Cir. 2002). "Substantial evidence is less than a preponderance but is enough that a reasonable mind would find it adequate to support the Commissioner's conclusion." Id.; accord Jones v. Barnhart, 335 F.3d 697, 698 (8th Cir. 2003). In determining whether the evidence is substantial, the court must consider evidence that detracts from, as well as supports, the Commissioner's decision. See Brosnahan v. Barnhart, 336 F.3d 671, 675 (8th Cir. 2003). So long as substantial evidence supports the final decision, the court may not reverse it merely because opposing substantial evidence exists in the record or because the court would have decided the case differently. See Krogmeier, 294 F.3d at 1022.

To be entitled to Title XVI benefits on account of disability, a claimant must prove that he is unable to perform any substantial gainful activity due to any medically determinable physical or mental impairment which would either result in death or which has lasted or could be expected to last for at least 12 months. See 42 U.S.C. §§ 423(a)(1)(D), (d)(1)(A), 1382c(a)(3)(A). A five-step

regulatory framework governs the evaluation of disability in general. See 20 C.F.R. §§ 404.1520, 416.920⁸; see also Bowen v. Yuckert, 482 U.S. 137, 140-41 (1987) (describing the five-step process); Fastner v. Barnhart, 324 F.3d 981, 983-84 (8th Cir. 2003).

Step One asks whether the claimant is engaged in "substantial gainful activity." 20 C.F.R. §§ 404.1520(b), 416.920(b). If he is engaged in such activity, disability benefits are denied. 20 C.F.R. §§ 404.1520(b), 416.920(b). If he is not, Step Two asks whether he has a "severe impairment," i.e., an impairment or combination of impairments which significantly limit his physical or mental ability to do basic work activities. 20 C.F.R. §§ 404.1520(c), 416.920(c). If he does not have a severe impairment or combination of impairments, the disability claim is denied. 20 C.F.R. §§ 404.1520(c), 416.920(c). If the impairment is severe, Step Three asks whether the impairment is equal to an impairment listed by the Commissioner as precluding substantial gainful activity. 20 C.F.R. §§ 404.1520(d), 416.920(d). "If the impairment meets or equals one of the listed impairments, the claimant is conclusively presumed to be disabled." Bowen, 482 U.S. at 141. If the impairment is not one that meets or equals one of the listed impairments, Step Four asks whether the impairment prevents the claimant from doing work he has performed in the past. 20 C.F.R. §§ 404.1520(e), 416.920(e). To determine whether a claimant can perform his past relevant work, the ALJ assesses and makes a finding about the claimant's RFC based on all the medical and other evidence in the case record. 20 C.F.R. § 404.1520(e);

⁸These Regulations were amended, effective September 25, 2003. See Clarification of Rules Involving Residual Functional Capacity Assessments; Clarification of Use of Vocational Experts and Other Sources at Step 4 of the Sequential Evaluation Process; Incorporation of "Special Profile" Into Regulations, 68 Fed. Reg. 51,153, 51,163, 55,164 (Aug. 26, 2003).

see 20 C.F.R. § 404.1545(a)(1) (RFC is the most a claimant can do despite his limitations).

The claimant has the burden of showing that he is unable to perform his past relevant work. Haley v. Massanari, 258 F.3d 742, 747 (8th Cir. 2001). If he is able to perform his previous work, he is not disabled. 20 C.F.R. §§ 404.1520(f), 416.920(f). If he cannot perform his past work, Step Five, the final step, asks whether the impairment or combination of impairments prevent him from making an adjustment to any other work. 20 C.F.R. §§ 404.1520(g)(1), 416.920(g)(1). If he can make such an adjustment, then he is not disabled. 20 C.F.R. §§ 404.1520(g)(1), 416.920(g)(1).

"A treating physician's opinion should not ordinarily be disregarded and is entitled to substantial weight." Singh v. Apfel, 222 F.3d 448, 452 (8th Cir. 2000). But "[c]ontrolling weight may not be given . . . unless the opinion is well-supported by medically acceptable clinical and laboratory diagnostic techniques." SSR 96-2p, 1996 WL 374188, at *1 (SSA July 2, 1996); accord Krogmeier, 294 F.3d at 1023. "Even if a treating source's medical opinion is well-supported, controlling weight may not be given to the opinion unless it also is 'not inconsistent' with the other substantial evidence in the case record." SSR 96-2p, 1996 WL 374188, at *1; accord Krogmeier, 294 F.3d at 1023.

In this case, substantial evidence supports the ALJ's determination that Dr. Morris's opinion did not warrant controlling weight or much deference. While Rule 96-2p requires that both clinical and laboratory diagnostic techniques support a treating physician's opinion if it is to be given controlling weight, Dr. Morris only cited to plaintiff's pain symptoms as the basis for the

opinion. In fact, he qualified his data as representing "an estimate only."⁹

Of greater note is the fact that Dr. Morris made no reference to any laboratory diagnostic technique in the opinion form he completed, even though the form urged him to do so; as the ALJ noted, diagnostic imaging failed to reveal an abnormality that would limit plaintiff as severely as Dr. Morris's opinion suggested; and Dr. Morris's examinations revealed few signs indicative of the limitations he assessed. For example, Dr. Morris's March 18, 2001 progress note states that plaintiff could carry out heel and toe walking with minimal difficulty, that his spine was grossly straight, that no real lumbar tenderness was noted, that no sciatic notch posterior thigh nor sacrioliac joint tenderness was noted, and that review of the March 2000 lumbar MRI scan showed normal alignment and "minimal" herniation of the L5-S1 disk.

As the ALJ also recognized, Dr. Morris recommended only analgesic medications and a walking program. Contrary to plaintiff's contention that the ALJ ignored the findings of Drs. Hosley and Conway (Doc. 17 at 11), the ALJ summarized their findings. The ALJ recognized that Dr. Hosley found plaintiff had mild discomfort and that Dr. Conway found a decreased range of motion in plaintiff's lumbar spine. See Riggins v. Apfel, 177 F.3d 689, 692 (8th Cir. 1999) (there is no doubt the claimant is experiencing pain, but real issue is severity of pain); Hutton v. Apfel, 175 F.3d 651, 654 (8th Cir. 1999).

⁹Although Dr. Morris qualified his June 1, 2001 opinion by stating that he was only estimating plaintiff's abilities, Dr. Morris merely recognized the obvious: a doctor's opinion on a patient's ability to do work-related activities is by its nature an estimate. Even the standard form Dr. Morris was asked to complete repeatedly used the word "about" before the time-frame boxes, e.g., Dr. Morris checked a box indicating plaintiff's maximum ability to stand and walk during a workday was "about 4 hrs." (Tr. 377-78.)

Just as substantial evidence supports the ALJ's treatment of Dr. Morris's opinion, so too does it support the ALJ's determination that plaintiff was not a fully credible witness. The ALJ cited to Polaski v. Heckler, 739 F.2d 1320, 1322 (8th Cir. 1984), and properly considered the factors set forth therein for assessing subjective complaints. As but one factor, the ALJ found that the objective medical evidence failed to support plaintiff's allegations about his physical limitations. Cf. O'Donnell v. Barnhart, 318 F.3d 811, 816-17 (8th Cir. 2003) ("an ALJ may not discount a claimant's allegations of disabling pain solely because the objective medical evidence does not fully support them" (emphasis added)); McClees v. Shalala, 2 F.3d 301, 302 (8th Cir. 1993). Additionally, the ALJ found that, although plaintiff had received epidural steroid injections and physical therapy, he did not list medications indicative of the severity of his alleged symptoms and Dr. Conway noted plaintiff had some improvement with physical therapy. See Richmond v. Shalala, 23 F.3d 1441, 1443-44 (8th Cir. 1994) (lack of strong pain medication is inconsistent with complaints of disabling pain); cf. Hutton v. Apfel, 175 F.3d 651, 655 (8th Cir. 1999) ("Impairments that are controllable or amenable to treatment do not support a finding of total disability."). Further, the ALJ found that plaintiff's daily activities, e.g., mowing his back yard, preparing meals, shopping, fishing, and caring for his ill significant other, contradicts his allegations about his limitations. See Haley, 258 F.3d at 748 ("Inconsistencies between subjective complaints of pain and daily living patterns diminish credibility"); Pena v. Chater, 76 F.3d 906, 908 (8th Cir. 1996) (affirming ALJ's discount of claimant's subjective complaints of pain where claimant was able to care for one of his children on daily basis, drive car infrequently, and grocery shop occasionally). Finally, some of the medical evidence—such as Dr. Conway's opinion that plaintiff's symptoms of low

chronic back pain were "certainly atypical" and Dr. Hosley's comment that there was "questionable" mild weakness with one of plaintiff's lower leg muscles--suggested plaintiff was exaggerating his limitations. See Jenkins v. Bowen, 861 F.2d 1083, 1086 (8th Cir. 1988) (exaggeration of symptoms is a factor to be weighed in evaluating subjective complaints of pain). For these reasons, the court will not disturb the ALJ's credibility determination. See Anderson v. Barnhart, No. 02-4119, 2003 WL 22227570, at *4 (8th Cir. Sept. 29, 2003) (a claimant's credibility is primarily a matter for the ALJ to decide).

The foregoing notwithstanding, the ALJ's determination that plaintiff can perform his past work as a security guard is not supported by substantial evidence. "Past work experience must be considered carefully to assure that the available facts support a conclusion regarding the claimant's ability or inability to perform the functional activities required in this work." SSR 82-62, 1982 WL 31386, at *3 (SSA 1983). Any case requiring consideration of past relevant work must contain enough information on past work to permit a decision as to the individual's ability to return to such past work. Id. This information can be derived from a "detailed description of the work obtained from the claimant, employer, or other informed source." Id. "[A]n ALJ has a duty to develop the record fully." Haley, 258 F.3d at 749.

In this case, the ALJ failed to comply with that duty regarding plaintiff's past relevant work as a security guard. Although the VE opined that plaintiff could perform his prior work as a security guard, the VE based his opinion on plaintiff's description of the job in Exhibit B-3E. That exhibit is far too imprecise to constitute substantial evidence. It merely indicates that plaintiff worked full-time watching a building. It does not specify the amount of walking--nor any other activity--plaintiff had to do as a security guard. Moreover, plaintiff testified that

he had to walk the floors of three-story buildings. Therefore, remand is required. See Pfitzner v. Apfel, 169 F.3d 566, 568-69 (8th Cir. 1999); Groeper v. Sullivan, 932 F.2d 1234, 1238 (8th Cir. 1991).

For the reasons set forth above, the decision of the Commissioner of Social Security is reversed under Sentence 4 of 42 U.S.C. § 405(g) and the action is remanded to the Commissioner for further proceedings. On remand, the ALJ shall develop the record further regarding a description of plaintiff's past relevant work as a security guard.¹⁰

An appropriate order is issued herewith.

DAVID D. NOCE
UNITED STATES MAGISTRATE JUDGE

Signed this _____ day of September, 2003.

¹⁰Plaintiff's argument regarding the transferability of his security skills is premature, given that the ALJ's analysis ended at Step 4 upon finding that plaintiff could perform his past relevant work. See 20 C.F.R. §§ 404.1520(a)(4) (if a claimant can be found disabled or not disabled at any step, a determination or decision is made and the next step is not reached); 404.1560(b)(3) (if a claimant has the RFC to do his past relevant work, his is not disabled; whether the past relevant work exists in significant numbers in the national economy will not be considered).