UNITED STATES DISTRICT COURT
DISTRICT OF RHODE ISLAND

JENNIFER S.	:	
	:	
v.	:	C.A. No. 18-00692-WES
	:	
ANDREW SAUL, Commissioner of the Social Security Administration	:	

REPORT AND RECOMMENDATION

Lincoln D. Almond, United States Magistrate Judge

This matter is before the Court for judicial review of a final decision of the Commissioner of the Social Security Administration ("Commissioner") denying Disability Insurance Benefits ("DIB") under the Social Security Act (the "Act"), 42 U.S.C. § 405(g). Plaintiff filed her Complaint on December 26, 2018 seeking to reverse the Decision of the Commissioner. On May 10, 2019, Plaintiff filed a Motion to Reverse the Decision of the Commissioner. (ECF Doc. No. 10). On June 4, 2019, the Commissioner filed a Motion for an Order Affirming the Decision of the Commissioner. (ECF Doc. No. 12). Plaintiff filed a Reply Brief on June 18, 2019. (ECF Doc. No. 13).

This matter has been referred to me for preliminary review, findings and recommended disposition. 28 U.S.C. § 636(b)(1)(B); LR Cv 72. Based upon my review of the record, the parties' submissions and independent research, I find that there is not substantial evidence in this record to support the Commissioner's decision and findings that Plaintiff is not disabled within the meaning of the Act. Consequently, I recommend that Plaintiff's Motion to Reverse (ECF Doc. No. 10) be GRANTED and that the Commissioner's Motion to Affirm (ECF Doc. No. 12) be DENIED.

I. PROCEDURAL HISTORY

Plaintiff filed an Application for DIB on April 19, 2017 alleging disability since January 20, 2017. (Tr. 143-144). The Application was denied initially on June 7, 2017 (Tr. 61-70) and on reconsideration on August 9, 2017 (Tr. 72-82). Plaintiff requested an Administrative Hearing. On June 27, 2018, a hearing was held before Administrative Law Judge Jason Mastrangelo (the "ALJ") at which time Plaintiff, represented by counsel, and a Vocational Expert ("VE") appeared and testified. (Tr. 32-59). The ALJ issued an unfavorable decision to Plaintiff on July 27, 2018. (Tr. 11-31). The Appeals Council denied Plaintiff's request for review on October 24, 2018. (Tr. 1-8). Therefore, the ALJ's decision became final. A timely appeal was then filed with this Court.

II. THE PARTIES' POSITIONS

Plaintiff argues that the ALJ failed to properly evaluate the medical opinion evidence and the credibility of her statements.

The Commissioner disputes Plaintiff's claims and contends that the ALJ's findings are supported by substantial evidence and must be affirmed.

III. THE STANDARD OF REVIEW

The Commissioner's findings of fact are conclusive if supported by substantial evidence. 42 U.S.C. § 405(g). Substantial evidence is more than a scintilla – i.e., the evidence must do more than merely create a suspicion of the existence of a fact, and must include such relevant evidence as a reasonable person would accept as adequate to support the conclusion. Ortiz v. Sec'y of HHS, 955 F.2d 765, 769 (1st Cir. 1991) (per curiam); Rodriguez v. Sec'y of HHS, 647 F.2d 218, 222 (1st Cir. 1981).

Where the Commissioner's decision is supported by substantial evidence, the court must affirm, even if the court would have reached a contrary result as finder of fact. Rodriguez Pagan

v. Sec'y of HHS, 819 F.2d 1, 3 (1st Cir. 1987); Barnes v. Sullivan, 932 F.2d 1356, 1358 (11th Cir. 1991). The court must view the evidence as a whole, taking into account evidence favorable as well as unfavorable to the decision. Frustaglia v. Sec'y of HHS, 829 F.2d 192, 195 (1st Cir. 1987); Parker v. Bowen, 793 F.2d 1177 (11th Cir. 1986) (court also must consider evidence detracting from evidence on which Commissioner relied).

The court must reverse the ALJ's decision on plenary review, however, if the ALJ applies incorrect law, or if the ALJ fails to provide the court with sufficient reasoning to determine that he or she properly applied the law. Nguyen v. Chater, 172 F.3d 31, 35 (1st Cir. 1999) (per curiam); accord Cornelius v. Sullivan, 936 F.2d 1143, 1145 (11th Cir. 1991). Remand is unnecessary where all of the essential evidence was before the Appeals Council when it denied review, and the evidence establishes without any doubt that the claimant was disabled. Seavey v. Barnhart, 276 F.3d 1, 11 (1st Cir. 2001) citing, Mowery v. Heckler, 771 F.2d 966, 973 (6th Cir. 1985).

The court may remand a case to the Commissioner for a rehearing under sentence four of 42 U.S.C. § 405(g); under sentence six of 42 U.S.C. § 405(g); or under both sentences. Seavey, 276 F.3d at 8. To remand under sentence four, the court must either find that the Commissioner's decision is not supported by substantial evidence, or that the Commissioner incorrectly applied the law relevant to the disability claim. Id.; accord Brenem v. Harris, 621 F.2d 688, 690 (5th Cir. 1980) (remand appropriate where record was insufficient to affirm, but also was insufficient for district court to find claimant disabled).

Where the court cannot discern the basis for the Commissioner's decision, a sentence-four remand may be appropriate to allow her to explain the basis for her decision. Freeman v. Barnhart, 274 F.3d 606, 609-610 (1st Cir. 2001). On remand under sentence four, the ALJ should review the case on a complete record, including any new material evidence. Diorio v. Heckler, 721 F.2d 726,

729 (11th Cir. 1983) (necessary for ALJ on remand to consider psychiatric report tendered to Appeals Council). After a sentence four remand, the court enters a final and appealable judgment immediately, and thus loses jurisdiction. Freeman, 274 F.3d at 610.

In contrast, sentence six of 42 U.S.C. § 405(g) provides:

> The court...may at any time order additional evidence to be taken before the Commissioner of Social Security, but only upon a showing that there is new evidence which is material and that there is good cause for the failure to incorporate such evidence into the record in a prior proceeding;

42 U.S.C. § 405(g). To remand under sentence six, the claimant must establish: (1) that there is new, non-cumulative evidence; (2) that the evidence is material, relevant and probative so that there is a reasonable possibility that it would change the administrative result; and (3) there is good cause for failure to submit the evidence at the administrative level. See Jackson v. Chater, 99 F.3d 1086, 1090-1092 (11th Cir. 1996).

A sentence six remand may be warranted, even in the absence of an error by the Commissioner, if new, material evidence becomes available to the claimant. Id. With a sentence six remand, the parties must return to the court after remand to file modified findings of fact. Id. The court retains jurisdiction pending remand, and does not enter a final judgment until after the completion of remand proceedings. Id

IV. THE LAW

The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months. 42 U.S.C. §§ 416(i), 423(d)(1); 20 C.F.R. § 404.1505. The impairment must be severe,

making the claimant unable to do her previous work, or any other substantial gainful activity which exists in the national economy. 42 U.S.C. § 423(d)(2); 20 C.F.R. §§ 404.1505-404.1511.

A. Medical and Nonmedical Sources[1]

The ALJ must consider the persuasiveness of all medical opinions[2] or prior administrative medical finding[3] in a claimant's case record. See 20 C.F.R. §§ 404.1520c, 416.920c. The persuasiveness of a medical opinion or finding is based on weighing the following factors in light of all of the evidence in the claim: (1) supportability; (2) consistency; (3) the medical source's relationship with the claimant[4]; (4) specialization; and (5) "other factors" that tend to support or contradict the medical opinion or finding. See 20 C.F.R. §§ 404.1520c(c)(1)-(5), 416.920(c)(1)-(5); see also Revisions to Rules Regarding the Evaluation of Medical Evidence, 82 Fed. Reg. 5844, 5859 (Jan. 18, 2017). Although no factor is assigned specific evidentiary weight, the most important factors are supportability and consistency.[5] 20 C.F.R. §§ 404.1520c(a), 416.920c(a). In

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[1] The Social Security Administration ("SSA") fundamentally changed how adjudicators assess evidence from a claimant's "treating source" effective for all applications to claims filed on or after March 27, 2017. For those claims, all adjudicators are no longer required to assign "controlling weight" to a treating source's medical opinion. Compare 20 C.F.R. §§ 404.1527(c)(2), 416.927(c)(2) (requiring adjudicators to give a treating source's medical opinion controlling weight that is related to the nature and severity of a claimant's impairment if it is "well-supported by medically acceptable clinical laboratory diagnostic techniques and is not inconsistent with the other substantial evidence" in the case record), with 20 C.F.R. §§ 404.1520(c)(a), 416.920(c)(a) (stating that adjudicators "will not defer or give any specific evidentiary weight, including controlling weight, to any medical opinion(s) or prior administrative medical finding(s), including those from your medical sources"). The SSA explained that it eliminated the treating source rule because "[m]any individuals receive health care from multiple medical sources...instead of from one treating [acceptable medical source]." Revisions to Rules Regarding the Evaluation of Medical Evidence, 82 Fed. Reg. 5844, 5853 (Jan. 18, 2017). Thus, according to SSA, the elimination of the treating source rule reflects the reality of the significant changes that have been made in the healthcare delivery system. Id.

[2] The SSA defines "medical opinion" as a "statement from a medical source about what you can still do despite your impairment(s) and whether you have one or more impairment-related limitation or restrictions in the abilities listed in [§ 416.913](a)(2)(i)(A) through (D) and [§ 416.913](a)(2)(ii)(A) through (F)." 20 C.F.R. § 416.913(a)(2)(i)-(i).

[3] For purposes of simplicity, "prior administrative medical finding" means "medical finding."

[4] This factor considers the length of treatment relationship, the purpose of the treatment relationship, scope of treatment relationship, and the examining relationship. 20 C.F.R. §§ 404.1520c(c)(3)(i)-(v), 416.920c(c)(3)(i)-(v).

[5] In this context, supportability "generally includes an assessment of the supporting objective medical evidence and other medical evidence, and how consistent the medical opinion or...medical findings is with other evidence in the claim." Revisions to Rules Regarding the Evaluation of Medical Evidence, 82 Fed. Reg. at 5859. However, the SSA recognizes that "a medical source

other words, "[a] medical opinion without supporting evidence, or one that is inconsistent with evidence from other sources, [is] not...persuasive regardless of who made the medical opinion." Revisions to Rules Regarding the Evaluation of Medical Evidence, 82 Fed. Reg. at 5854 (alterations in original). Moreover, the ALJ need not "defer or give any specific evidentiary weight, including controlling weight, to any medical opinion(s) or prior administrative finding(s), including those from [the claimant's] medical sources." 20 C.F.R. §§ 404.1520c(a), 416.920c(a) (alteration in original).

The ALJ's decision, at a minimum, must articulate how the supportability and consistency factors were considered. 20 C.F.R. §§ 404.1520c(b)(2), 416.920c(b)(2). Additionally, if the record contains "two or more medical opinions... about the same issue [that] are both equally well-supported...and consistent with the record," the ALJ's decision must articulate how the other most persuasive factors were considered. 20 C.F.R. §§ 404.1520c(b)(3), 416.920c(b)(3). On the other hand, the ALJ bears no articulation burden regarding how nonmedical sources were considered. 20 C.F.R. §§ 404.1520c(d), 416.920c(d).

Due to changes in the modern healthcare delivery system, the SSA expanded the definition of "acceptable medical source" to include advanced practice registered nurses (APRN)[6] and physician assistants.[7] 20 C.F.R. §§ 404.1502(a)(7)-(8), 416.902(a)(7)-(8); Revisions to Rules Regarding the Evaluation of Medical Evidence, 82 Fed. Reg. at 5845-5846. Only an acceptable

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who has a longstanding treatment relationship with an individual may contain some inconsistencies over time due to fluctuations in the severity of an individual's impairments." Id. at 5857.

[6] "APRNs include four types of medical sources: Certified Nurse Midwife, Nurse Practitioner, Certified Registered Nurse Anesthetist, and Clinical Nurse Specialist." Revisions to Rules Regarding the Evaluation of Medical Evidence, 82 Fed. Reg. at 5846.

[7] The regulations recognize other categories of providers as acceptable medical sources for certain impairments; for example, a licensed optometrist is acceptable for measurement of visual acuity and visual fields. 20 C.F.R. §§ 404.1502(3), 416.902(3).

medical source may provide a medical opinion to establish the existence of a medically determinable impairment.[8] 20 C.F.R. §§ 404.1521, 416.921 ("[A] physical or mental impairment must be established by objective medical evidence from an acceptable medical source."). In general, an opinion from a nonmedical source is not entitled to the same deference as an opinion from a medical source. See 20 C.F.R. §§ 404.1520c(d), 416.920c(d). Nevertheless, the opinions of nonmedical sources are important and should be evaluated on key issues such as severity and functional effects, along with other relevant evidence in the file. See SSR 16-3P, 2017 WL 4790249, at *6 (Oct. 25, 2017).

The ALJ is required to review all of the medical findings and other evidence that support a medical source's statement that a claimant is disabled. 20 C.F.R. §§ 404.1520b, 416.920b. However, the ALJ is responsible for making the ultimate determination about whether a claimant meets the statutory definition of disability. 20 C.F.R. §§ 404.1520b(c)(3), 416.920b(c)(3). The ALJ is not required to give any special significance to the status of a physician as treating or non-treating in weighing an opinion on whether the claimant meets a listed impairment, a claimant's residual functional capacity ("RFC"), see 20 C.F.R. §§ 404.1545-1546, 416.945-416.946, or the application of vocational factors because that ultimate determination is the province of the Commissioner. See Dudley v. Sec'y of HHS, 816 F.2d 792, 793-794 (1st Cir. 1987) (per curiam).

B. Developing the Record

The ALJ has a duty to fully and fairly develop the record. Heggarty v. Sullivan, 947 F.2d 990, 997 (1st Cir. 1991). The Commissioner also has a duty to notify a claimant of the statutory right to retained counsel at the social security hearing, and to solicit a knowing and voluntary

[8] See Revisions to Rules Regarding the Evaluation of Medical Evidence, 82 Fed. Reg. at 5847.

waiver of that right if counsel is not retained. See 42 U.S.C. § 406; Evangelista v. Sec'y of HHS, 826 F.2d 136, 142 (1st Cir. 1987). The obligation to fully and fairly develop the record exists if a claimant has waived the right to retained counsel, and even if the claimant is represented by counsel. Id. However, where an unrepresented claimant has not waived the right to retained counsel, the ALJ's obligation to develop a full and fair record rises to a special duty. See Heggarty, 947 F.2d at 997, citing Currier v. Sec'y of Health Educ. and Welfare, 612 F.2d 594, 598 (1st Cir. 1980).

C. Medical Tests and Examinations

The ALJ is required to order additional medical tests and exams only when a claimant's medical sources do not give sufficient medical evidence about an impairment to determine whether the claimant is disabled. 20 C.F.R. § 416.917; see also Conley v. Bowen, 781 F.2d 143, 146 (8th Cir. 1986). In fulfilling his duty to conduct a full and fair inquiry, the ALJ is not required to order a consultative examination unless the record establishes that such an examination is necessary to enable the ALJ to render an informed decision. Carrillo Marin v. Sec'y of HHS, 758 F.2d 14, 17 (1st Cir. 1985).

D. The Five-step Evaluation

The ALJ must follow five steps in evaluating a claim of disability. See 20 C.F.R. §§ 404.1520, 416.920. First, if a claimant is working at a substantial gainful activity, she is not disabled. 20 C.F.R. § 404.1520(b). Second, if a claimant does not have any impairment or combination of impairments which significantly limit her physical or mental ability to do basic work activities, then she does not have a severe impairment and is not disabled. 20 C.F.R. § 404.1520(c). Third, if a claimant's impairments meet or equal an impairment listed in 20 C.F.R. Part 404, Subpart P, Appendix 1, she is disabled. 20 C.F.R. § 404.1520(d). Fourth, if a claimant's

impairments do not prevent her from doing past relevant work, she is not disabled. 20 C.F.R. § 404.1520(e). Fifth, if a claimant's impairments (considering her RFC, age, education, and past work) prevent her from doing other work that exists in the national economy, then she is disabled. 20 C.F.R. § 404.1520(f). Significantly, the claimant bears the burden of proof at steps one through four, but the Commissioner bears the burden at step five. Wells v. Barnhart, 267 F. Supp. 2d 138, 144 (D. Mass. 2003) (five-step process applies to both SSDI and SSI claims).

In determining whether a claimant's physical and mental impairments are sufficiently severe, the ALJ must consider the combined effect of all of the claimant's impairments, and must consider any medically severe combination of impairments throughout the disability determination process. 42 U.S.C. § 423(d)(2)(B). Accordingly, the ALJ must make specific and well-articulated findings as to the effect of a combination of impairments when determining whether an individual is disabled. Davis v. Shalala, 985 F.2d 528, 534 (11th Cir. 1993).

The claimant bears the ultimate burden of proving the existence of a disability as defined by the Social Security Act. Seavey, 276 F.3d at 5. The claimant must prove disability on or before the last day of her insured status for the purposes of disability benefits. Deblois v. Sec'y of HHS, 686 F.2d 76 (1st Cir. 1982), 42 U.S.C. §§ 416(i)(3), 423(a), (c). If a claimant becomes disabled after she has lost insured status, her claim for disability benefits must be denied despite her disability. Id.

E. Other Work

Once the ALJ finds that a claimant cannot return to her prior work, the burden of proof shifts to the Commissioner to establish that the claimant could perform other work that exists in the national economy. Seavey, 276 F.3d at 5. In determining whether the Commissioner has met this burden, the ALJ must develop a full record regarding the vocational opportunities available to

a claimant. Allen v. Sullivan, 880 F.2d 1200, 1201 (11th Cir. 1989). This burden may sometimes be met through exclusive reliance on the Medical-Vocational Guidelines (the "grids"). Seavey, 276 F.3d at 5. Exclusive reliance on the "grids" is appropriate where the claimant suffers primarily from an exertional impairment, without significant non-exertional factors. Id.; see also Heckler v. Campbell, 461 U.S. 458 (1983) (exclusive reliance on the grids is appropriate in cases involving only exertional impairments, impairments which place limits on an individual's ability to meet job strength requirements).

Exclusive reliance is not appropriate when a claimant is unable to perform a full range of work at a given residual functional level or when a claimant has a non-exertional impairment that significantly limits basic work skills. Nguyen, 172 F.3d at 36. In almost all of such cases, the Commissioner's burden can be met only through the use of a vocational expert. Heggarty, 947 F.2d at 996. It is only when the claimant can clearly do unlimited types of work at a given residual functional level that it is unnecessary to call a vocational expert to establish whether the claimant can perform work which exists in the national economy. See Ferguson v. Schweiker, 641 F.2d 243, 248 (5th Cir. 1981). In any event, the ALJ must make a specific finding as to whether the non-exertional limitations are severe enough to preclude a wide range of employment at the given work capacity level indicated by the exertional limitations.

1. Pain

"Pain can constitute a significant non-exertional impairment." Nguyen, 172 F.3d at 36. Congress has determined that a claimant will not be considered disabled unless he furnishes medical and other evidence (e.g., medical signs and laboratory findings) showing the existence of a medical impairment which could reasonably be expected to produce the pain or symptoms alleged. 42 U.S.C. § 423(d)(5)(A). The ALJ must consider all of a claimant's statements about

his symptoms, including pain, and determine the extent to which the symptoms can reasonably be accepted as consistent with the objective medical evidence. 20 C.F.R. § 404.1528. In determining whether the medical signs and laboratory findings show medical impairments which reasonably could be expected to produce the pain alleged, the ALJ must apply the First Circuit's six-part pain analysis and consider the following factors:

> (1) The nature, location, onset, duration, frequency, radiation, and intensity of any pain;
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> (2) Precipitating and aggravating factors (e.g., movement, activity, environmental conditions);
>
> (3) Type, dosage, effectiveness, and adverse side-effects of any pain medication;
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> (4) Treatment, other than medication, for relief of pain;
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> (5) Functional restrictions; and
>
> (6) The claimant's daily activities.

Avery v. Sec'y of HHS, 797 F.2d 19, 29 (1st Cir. 1986). An individual's statement as to pain is not, by itself, conclusive of disability. 42 U.S.C. § 423(d)(5)(A).

2. Credibility

Where an ALJ decides not to credit a claimant's testimony about pain, the ALJ must articulate specific and adequate reasons for doing so, or the record must be obvious as to the credibility finding. Rohrberg, 26 F. Supp. 2d at 309. A reviewing court will not disturb a clearly articulated credibility finding with substantial supporting evidence in the record. See Frustaglia, 829 F.2d at 195. The failure to articulate the reasons for discrediting subjective pain testimony requires that the testimony be accepted as true. See DaRosa v. Sec'y of Health and Human Servs., 803 F.2d 24 (1st Cir. 1986).

A lack of a sufficiently explicit credibility finding becomes a ground for remand when credibility is critical to the outcome of the case. See Smallwood v. Schweiker, 681 F.2d 1349, 1352 (11th Cir. 1982). If proof of disability is based on subjective evidence and a credibility determination is, therefore, critical to the decision, "the ALJ must either explicitly discredit such testimony or the implication must be so clear as to amount to a specific credibility finding." Foote v. Chater, 67 F.3d 1553, 1562 (11th Cir. 1995) (quoting Tieniber v. Heckler, 720 F.2d 1251, 1255 (11th Cir. 1983)).

V. APPLICATION AND ANALYSIS

A. The ALJ's Decision

The ALJ decided this case adverse to Plaintiff at Step 5. At Step 2, the ALJ found that Plaintiff's migraines were a severe impairment. (Tr. 16). At Step 3, the ALJ found that Plaintiff did not have an impairment or a combination of impairments that met or medically equaled a Listing. (Tr. 20-21). The ALJ then determined that Plaintiff retained the RFC to perform medium work, as defined by 20 C.F.R. § 404.1567(c), and she could sit and stand and/or walk for six hours each in an eight-hour day. (Tr. 21). The ALJ also found that Plaintiff could frequently climb ramps and stairs, but never ladders, ropes or scaffolds; she could frequently balance, stoop, kneel, crouch and crawl; and she should avoid concentrated exposure to noise and even moderate exposure to hazardous machines and heights. Id. At Step 4, the ALJ found that Plaintiff could not perform her past relevant work. (Tr. 25). At Step 5, the ALJ concluded that there were other jobs in the national economy that Plaintiff could perform, including the representative medium, unskilled occupations of packager, kitchen helper and stock clerk. (Tr. 26-27). Accordingly, the ALJ concluded that Plaintiff was not disabled from January 20, 2017 through the date of the decision. (Tr. 27).

B. The ALJ Erred in his Evaluation of the Treating Neurologist's Opinion

Plaintiff argues that the ALJ erred in his conclusion that the opinions from treating neurologist Dr. Aumentado were conclusory and unpersuasive. (Tr. 25). Defendant counters that the ALJ's reasons for discounting the opinions of Dr. Aumentado and relying on the consulting opinions of Dr. Callaghan are well-supported and constitute substantial evidence for the ALJ's RFC assessment.

By way of background, Plaintiff primarily contends that she is unable to sustain full-time employment due to chronic migraines. Prior to applying for DIB in 2017, Plaintiff worked nearly twenty years at a Retail Distribution Center, last holding the position of forklift operator. She testified that she "could not complete a workweek without calling out four out of five days" and ultimately lost employment because she was out on FMLA short-term disability and "they no longer held my job position." (Tr. 39-40).

The ALJ found that Plaintiff's migraines were a severe impairment at Step 2. However, in making his RFC finding, the ALJ gave reduced weight to the opinions of Plaintiff's treating neurologist, Dr. Aumentado, and found the assessments of the consulting physicians, particularly Dr. Callaghan, to be "extremely persuasive." (Tr. 23-25). Plaintiff argues that the ALJ's conclusions are unsupported by the record and that Dr. Aumentado was in the best position as a treating neurologist who saw her on a regular basis to opine on the frequency and severity of her migraine headaches.

On July 7, 2017, Dr. Aumentado completed an impairment questionnaire specific to headaches. (Exh. 7F). He indicated that Plaintiff suffered from "frequent disabling migraines" and would likely be absent from work more than three times per month. (Tr. 292, 296). The VE

testified that this level of absenteeism would rule out full-time, competitive employment. (Tr. 57). Thus, if accepted, Dr. Aumentado's opinions would result in a disability finding.

The ALJ generally cites to Dr. Aumentado's July 7, 2017 questionnaire (Exh. 7F) for the proposition that he "documented improvement in her symptoms with treatment." (Tr. 22). This is not a fair reading of Dr. Aumentado's opinions in the context of his treatment records. First, the questionnaire clearly opines that Plaintiff has frequent, disabling migraines that would result in more than three absences from work each month. (Tr. 292, 296). Second, the treatment records do not document sustained improvement. For instance, the July 6, 2017 treatment note indicates that Botox therapy[9] resulted in a temporary reduction to two headaches per week but returning to daily after a period. (Tr. 280). He also records that Treximet has been "variable effective" and using Naproxen and Treximet for acute therapy was "ineffective." Id. The May 3, 2017 treatment note reports that Plaintiff "continues to have daily HA" and the June 2, 2017 treatment note reports three headaches per week and that Treximet is "no longer covered" and Migranal was "not effective." (Tr. 262, 283). The October 10, 2017 treatment note indicates that Plaintiff missed her Botox therapy in July due to a change in health insurance, and headache frequency is now daily. (Tr. 286). The note reports that "sprix works" but causes Plaintiff to fall asleep after taking it. Id.

Because the ALJ does not directly confront and resolve the issue of absenteeism and ability to stay on task, I conclude that a remand is warranted. The record is clear that Plaintiff suffers from frequent, chronic migraines and is unable to work or perform household tasks when afflicted. The ALJ seems to accept this when finding that Plaintiff "is independent with daily activities when she does not experience migraines." (Tr. 22). The ALJ rejected Dr. Aumentado's opinion as to

[9] The ALJ describes the Botox injections as "conservative" treatment but it required insurance pre-approval, and each treatment consisted of 155 units administered "via 31 injections on the face, head, neck and shoulders." (Tr. 286).

absenteeism because it lacked specificity and was contained in a form containing a series of checked boxes. (Tr. 25). The ALJ also faulted the opinions for being conclusory and not "objectively quantified." Id.[10] While the opinions are set forth in a check-mark questionnaire, Dr. Aumentado provides supporting explanation where requested, including the nature of the headaches, treatment[11] and response to treatment. (Exh. 7F). The opinions are also entirely consistent with Dr. Aumentado's treatment records and Plaintiff's testimony and work history. The ALJ never rejects Plaintiff's description of the nature and frequency of her migraines, or the impact of them on her ability to go to work.

The bottom line is that the ALJ never directly addresses the credibility of the reported frequency or the impact of such migraines on Plaintiff's attendance and ability to sustain full-time employment. See Amanda S. v. Berryhill, No. 18-0001-JJM, 2019 WL 1316979 at *6 (D.R.I. March 22, 2019). Further, while Dr. Sarpolis and Dr. Callaghan reviewed the majority of medical records documenting Plaintiff's history of migraines, they completed a physical RFC assessment that did not specifically address the issue of attendance. (Tr. 67-68, 78-80). Further, it does not appear that either reviewing physician had the benefit of reviewing Dr. Aumentado's July 7, 2017 opinions. (See Tr. 62-63, 73-75).

CONCLUSION

For the reasons discussed herein, I recommend that Plaintiff's Motion to Reverse (ECF Doc. No. 10) be GRANTED and that the Commissioner's Motion to Affirm (ECF Doc. No. 12)

[10] Courts have recognized that "migraines pose a difficult challenge because the diagnosis is based largely on symptoms reported by a claimant, not objective evidence." Dunn v. Colvin, No. 15-cv-13390, 2016 WL 4435079 at *12 (D. Mass. Aug. 19, 2016). Here, it is unclear what additional specificity or objective quantification could be provided beyond what is contained in Dr. Aumentado's treatment records and Plaintiff's statements.

[11] Due to the frequency of Plaintiff's migraines and ineffectiveness of oral medications, Dr. Aumentado sought insurance preauthorization for Botox injections on February 7, 2017. (Tr. 270). She was approved for Botox (Tr. 265) and received a treatment on April 21, 2017. (Tr. 264-265). On May 3, 2017, she reported that she continued to have daily headaches. (Tr. 262). Plaintiff later reported temporary relief with Botox with a reduction to two to three headaches per week. (Tr. 42).

be DENIED. I further recommend that Final Judgment enter in favor of Plaintiff remanding this matter for additional administrative proceedings consistent with this decision.

Any objection to this Report and Recommendation must be specific and must be filed with the Clerk of the Court within fourteen days of its receipt. See Fed. R. Civ. P. 72(b); LR Cv 72. Failure to file specific objections in a timely manner constitutes waiver of the right to review by the District Court and the right to appeal the District Court's decision. See United States v. Valencia-Copete, 792 F.2d 4, 6 (1st Cir. 1986); Park Motor Mart, Inc. v. Ford Motor Co., 616 F.2d 603, 605 (1st Cir. 1980).

/s/ Lincoln D. Almond
LINCOLN D. ALMOND
United States Magistrate Judge
July 10, 2019